Canadian Hospital

- *Obligations to the Ambulatory Patient*
- *Modern New Niagara Cottage Hospital*
- *Seventh Western Canada Institute*
- *Maritime Hospitals' Convention*

JULY, 1952

Official Journal—Canadian Hospital Council

QUALITY IS A HABIT WITH CANADIAN

In the modern factory of The Canadian Laundry Machinery Co., quality is not merely strived for, but consistently attained in every machine produced. In every department, all efforts are continually directed toward making CANADIAN laundry equipment the finest possible. That is why each machine is quality-built for many years of dependable and superior performance.

Leading hospitals throughout the country will attest to the fine and constant quality of their CANADIAN-equipped laundry departments. They know that painstaking research and development by our engineers have perfected an outstanding line of laundry equipment for every size hospital . . . that behind each modern installation stands CANADIAN'S complete planning, advisory and technical service, to assure that each machine is best suited to their particular needs.

More than a symbol, quality is a *faithfully practiced habit* at The Canadian Laundry Machinery Co.

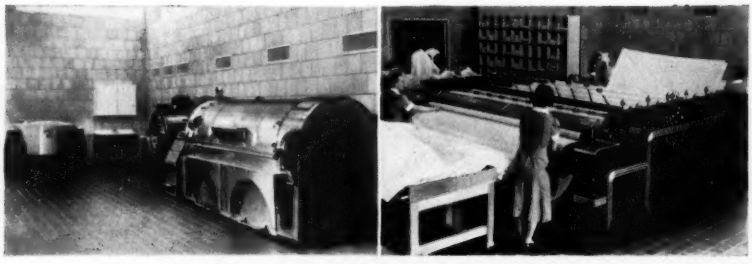
The

CANADIAN

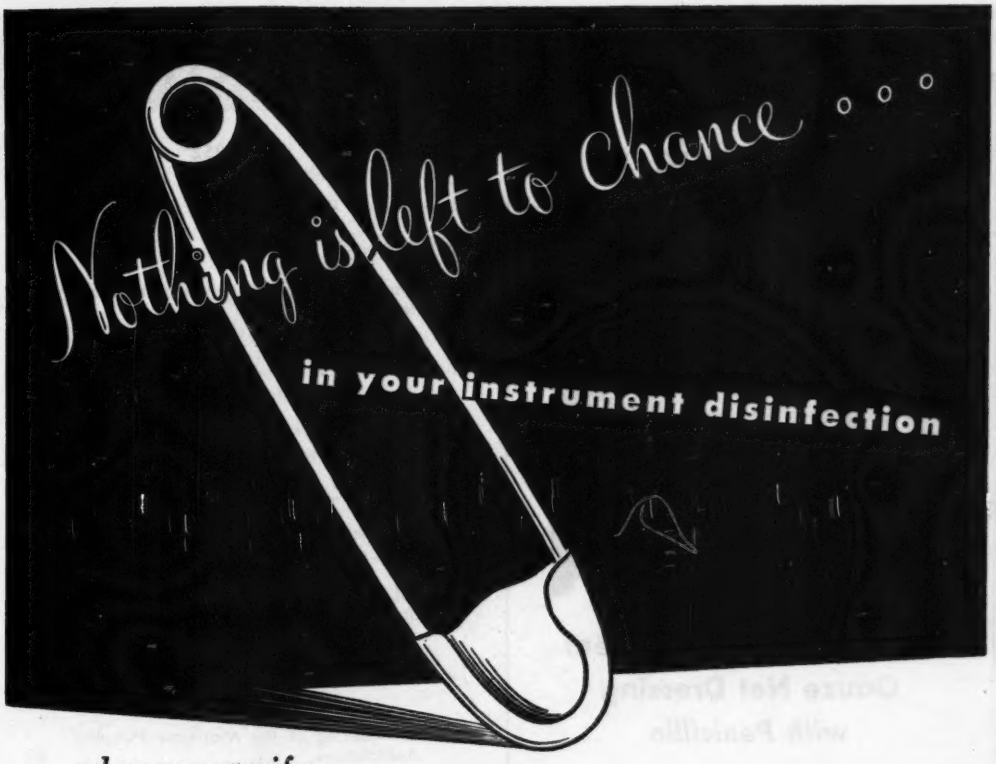
LAUNDRY MACHINERY CO., LIMITED

47-93 STERLING ROAD, TORONTO 3, ONT.

WESTERN REPRESENTATIVES—Stanley Brock Limited, Winnipeg, Calgary, Edmonton, Vancouver.



At New Aberhart Memorial Sanatorium, Edmonton, Alberta, laundry department was planned and completely equipped by CANADIAN. Shown at left, above, are CASCADE Automatic Unloading Washer with Full-Automatic Washing Control, CASCADE End-Loading Washer and NOTRUX Extractor. At right is 6-Roll SUPER-SYLON Flatwork Ironer.



when you specify

BARD-PARKER FORMALDEHYDE GERMICIDE

containing HEXACHLOROPHENE (G-11*)

• • • because it has established a new standard of potency for solutions used in the chemical disinfection of surgical instruments. It will destroy vegetative pathogens and spore formers within 5 minutes, and the spores themselves within 3 hours—as shown in the comparative chart. In addition, it is "economically usable" as prolonged immersion of delicate steel instruments will not result in rust or corrosive damage to keen cutting edges. The Solution will retain its high disinfecting potency over long periods of use if kept undiluted and free of foreign matter.

*Trademark of Sindar Corp.

PARKER, WHITE & HEYL, INC. • Danbury, Connecticut

For practical purposes we suggest the selection of B-P CONTAINERS — all scientifically designed for use with the Solution.

Compare this significant data evaluating the potency of the IMPROVED germicide

SPORULATING BACTERIA	50% DRIED BLOOD	WITHOUT BLOOD
Cl. tetani	3 hours	3 hours
Cl. welchii	2 hours	2 hours
B. anthracis	1½ hours	1½ hours
VEGETATIVE BACTERIA		
Staph. aureus	5 min.	15 sec.
E. coli	3 min.	15 sec.
Strept. hemolyticus	2 min.	15 sec.

Ask your dealer

Contents

Vol. 29 **July, 1952** No. 7

(For Subscription Rates, see page 74)

FOR INCREASED CARBOHYDRATE ALIMENTATION

With *10% Travert* solutions, a patient's carbohydrate needs can be more nearly satisfied within a reasonable time with no increase in fluid volume or vein damage.

Travert solutions are sterile, crystal-clear, colorless, non-pyrogenic and non-antigenic. They are prepared by the hydrolysis of cane sugar and are composed of equal parts of D-glucose (dextrose) and D-fructose (levulose).

Travert solutions are available in water or saline in 150 cc., 500 cc., 1000 cc. sizes. For the treatment of potassium deficiency, *10% Travert* solutions with 0.3% potassium chloride are also available in 1000 cc. containers.

Travert is a trademark of BAXTER LABORATORIES, INC.

products of
BAXTER LABORATORIES OF CANADA, LTD.
Acton, Ontario

Distributed in Canada exclusively by
INGRAM & BELL LIMITED
TORONTO
MONTREAL · WINNIPEG · CALGARY · VANCOUVER

Greater patient comfort.

Drainage absorbs into the pad—immediately. Protects against running off the sides onto the bed linen.

Only TRI-PAD* has all these advantages

Retains over 20% more drainage than any other commercially made pad.

Wet or dry—sterilized or unsterilized—facing and repellent backing stand up under extreme tension.

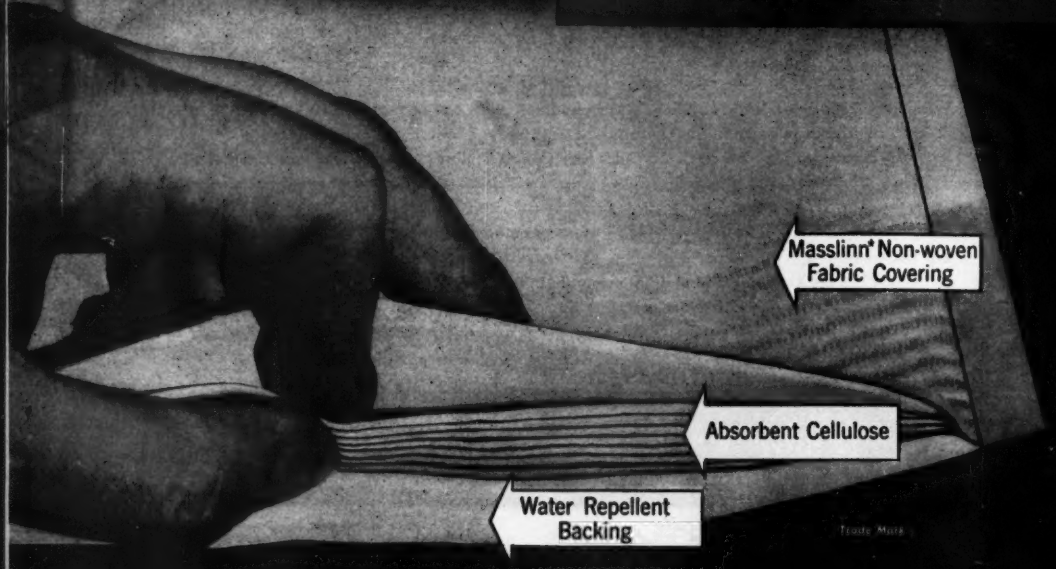
Less frequent linen changes—more time for more important duties.

and Laundry Burden

Sheets last longer with fewer changes—reduces laundry costs.

Eliminates waste of time and materials.

Johnson & Johnson
LIMITED MONTREAL



*Trade Mark

Canadian Hospital Council

The Federation of Hospital Associations in Canada in co-operation with the Federal and Provincial Governments, the Canadian Medical Association, and the Blue Cross Plans.

Officers and Directors

HONORARY PRESIDENT:
THE HONOURABLE PAUL MARTIN
Minister of National Health and Welfare

HONORARY VICE-PRESIDENT:
R. FRASER ARMSTRONG, B.Sc.
Kingston General Hospital, Kingston

PRESIDENT:
O. C. TRAINOR, M.D.
Misericordia Hospital, Winnipeg

FIRST VICE-PRESIDENT:
A. C. McGUGAN, M.D.
University of Alberta Hospital, Edmonton

SECOND VICE-PRESIDENT:
REV. FATHER HECTOR L. BERTRAND, S.J.
325 St. Catherine Road, Montreal

TREASURER:
A. LORNE C. GILDAY, M.D., C.M.
478 Mountain Ave., Westmount, Montreal

DIRECTORS:
REV. SISTER M. IGNATIUS
Sisters of St. Martha, Antigonish, N.S.

PERCY WARD
129 Osborne Road East, North Vancouver

J. GILBERT TURNER, M.D., C.M.
Royal Victoria Hospital, Montreal

HAROLD E. BAIRD, M.D.
Regina General Hospital, Regina

DONALD F. W. PORTER, M.D.
The Moncton Hospital, Moncton

W. DOUGLAS PIERCEY, M.D.
Ottawa Civic Hospital, Ottawa

Editorial Board

R. FRASER ARMSTRONG, B.Sc.
Kingston General Hospital, Kingston

HARVEY AGNEW, M.D.
134 Bloor St. West, Toronto 5

PRISCILLA CAMPBELL, Reg.N.
Public General Hospital, Chatham, Ont.

D. R. EASTON, M.D.
Royal Alexandra Hospital, Edmonton

RENE LAPORTE
Hôpital Notre-Dame, Montreal

REV. SISTER CATHERINE GERARD
Halifax Infirmary, Halifax

RUTH C. WILSON
Maritime Hospital Service Association Moncton, N.B.

PROVINCIAL CORRESPONDENTS:

British Columbia: PERCY WARD, *Vancouver*

Alberta: M. G. McCALLUM, M.D., *Edmonton*

Saskatchewan: S. N. WYNN, *Yorkton*

Manitoba: PAUL D. SHANNON, *Winnipeg*

Ontario: OCEAN G. SMITH, *Toronto*

Quebec: A. L. C. GILDAY, M.D., C.M., *Montreal*

Maritimes: MRS. H. W. PORTER, *Kentville, N.S.*

Executive Staff

L. O. BRADLEY, M.D.,
Executive Secretary and Editor

MURRAY W. ROSS,
Associate Secretary and Associate Editor

DONALD M. MacINTYRE,
Assistant Secretary

CHARLES A. EDWARDS,
Business Manager
(57 Bloor St. W.)

JESSIE FRASER, M.A.,
Assistant Editor

Editorial and Secretarial Offices: 280 Bloor St. West, Toronto 5, Ont.

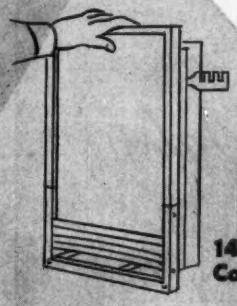
No matter what your TB there's a GE Photoroentgen

Duplex Self-Contained Photoroentgen Unit

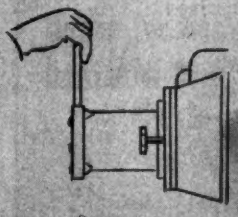
Single-Stand Photoroentgen Unit

case-finding program...
unit to match your needs

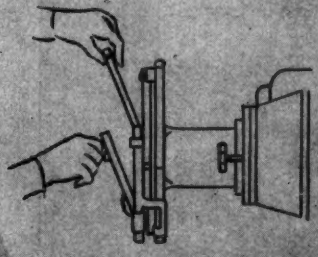
Duplex — completely self-contained x-ray facilities — institutional or mobile units. *Single* — complete camera unit on stand — for use with existing x-ray equipment. Life-size (14" x 17"), 4" x 5", 4" x 10" or 70 mm film. You can select the specific apparatus to fill your exact diagnostic requirements from the complete line of time-tested General Electric Photoroentgen Units. Whether you examine hundreds of patients daily or just a few a week, it will pay you to talk over your needs with your GE x-ray representative. Phone or write the nearest office of General Electric X-Ray Corp., Ltd. — Montreal, Toronto, Vancouver, Winnipeg.



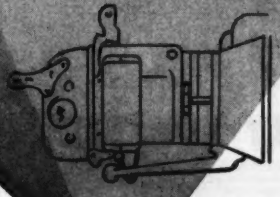
14 by 17 inch Film Cassette Channel



Camera Back for 4 by 5 inch Cut-Film



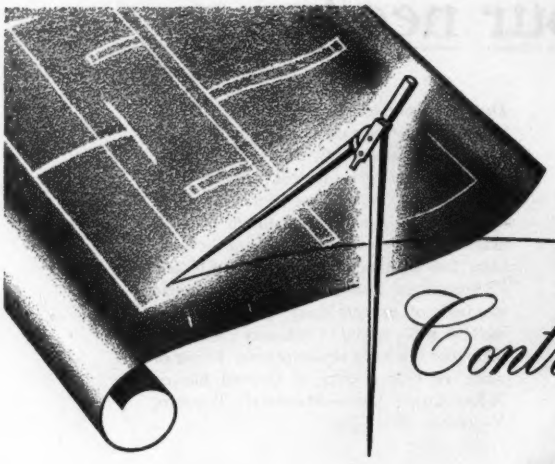
Camera Back for 4 by 10 inch Cut-Film



Camera for 70 mm Roll-Film

You can put your confidence in —

GENERAL ELECTRIC



Contract Sales

TIMCO-FURNISHED hospitals, schools and institutions have the finest of modern equipment . . . including custom-made draperies and Royalchrome Furniture, Hall Hospital Furniture, American Hospital Supply Tomac Modern Basinettes, Jiffy-Join Silent Cubicles, ward furniture in wood or metal suites, Prolon Dinnerware, sheeting, textiles, etc. . . . everything required for bedrooms, reception rooms, dining rooms, offices and classrooms.

We also carry a complete range of habit fabrics for nursing sisters, including serges, sayes and imported veilings.

Let our experts assist you in planning your furnishings.
Our representative will be glad to call.

★TIMCO★

The MICHAEL TIMCO COMPANY LIMITED

221 Kenilworth Ave. N. **Phone 5-9252** **Hamilton, Ontario**

◂ Notes About People ▸

Gordon A. Friesen Resigns from Kitchener-Waterloo Hospital

Gordon A. Friesen, administrator of the Kitchener-Waterloo Hospital, Kitchener, Ont., has accepted a position as principal consultant in hospital administration to the three non-profit Memorial Hospital Associations of Kentucky, West Virginia, and Virginia. The Associations are being sponsored by the Welfare and Retirement Fund of the United Mine Workers of America for the purpose of constructing 10 community hospitals in the three states. Mr. Friesen will play an important role in planning, equipping, and supervising the administration of the 10 hospitals. It is expected that he will take up his new duties later this summer, with headquarters in Washington, D.C.

Mr. Friesen has had wide experience in the hospital field and began his career, in 1929, as business manager of the Saskatoon City Hospital, Saskatoon, Sask. In 1937, he was appointed administrator of the Belleville General Hospital, Belleville, Ont., a position he held until his enlistment in the medical branch of the Royal Canadian Air Force in 1941. After serving as military governor of Kreis Brilon, Germany, Mr. Friesen returned to Canada and, in November of that year, became administrator of the Kitchener-Waterloo Hospital. The best wishes of his many friends go with him as he assumes his new and challenging position.

* * * *

Appointment of Gertrude M. Hall Announced by Calgary General Hospital

Gertrude M. Hall, general secretary of the Canadian Nurses' Association and national advisor on nursing, has been appointed director of nurses at the Calgary General Hospital, Calgary, Alta., and will take up her new duties early in October. Miss Hall, a native of Winnipeg, Man., is a graduate of the Winnipeg General Hospital. After taking post-graduate training in public health teaching and supervision at

(Continued on page 16)

Gertrude M. Hall

THE LIEBEL-FLARSHEIM COMPANY

announces
the appointment of

X-ray AND Radium

as exclusive Canadian representatives for Liebel-Flarsheim equipment, effective June 1, 1952.

As part of our policy to supply the medical profession with improved products and service at all times, we are pleased to announce the availability of our units through this nationally known organization.

The highly trained personnel and all-round company experience of X-Ray and Radium Industries Limited will, we feel, assure Canadian doctors of quick, accurate service at all times.

X-Ray and Radium Industries Limited
Head Office is located at 261 Davenport Road—Toronto 5.
With branches from coast to coast in Canada

L-F Units now available to Canadian Physicians include:

Bovie

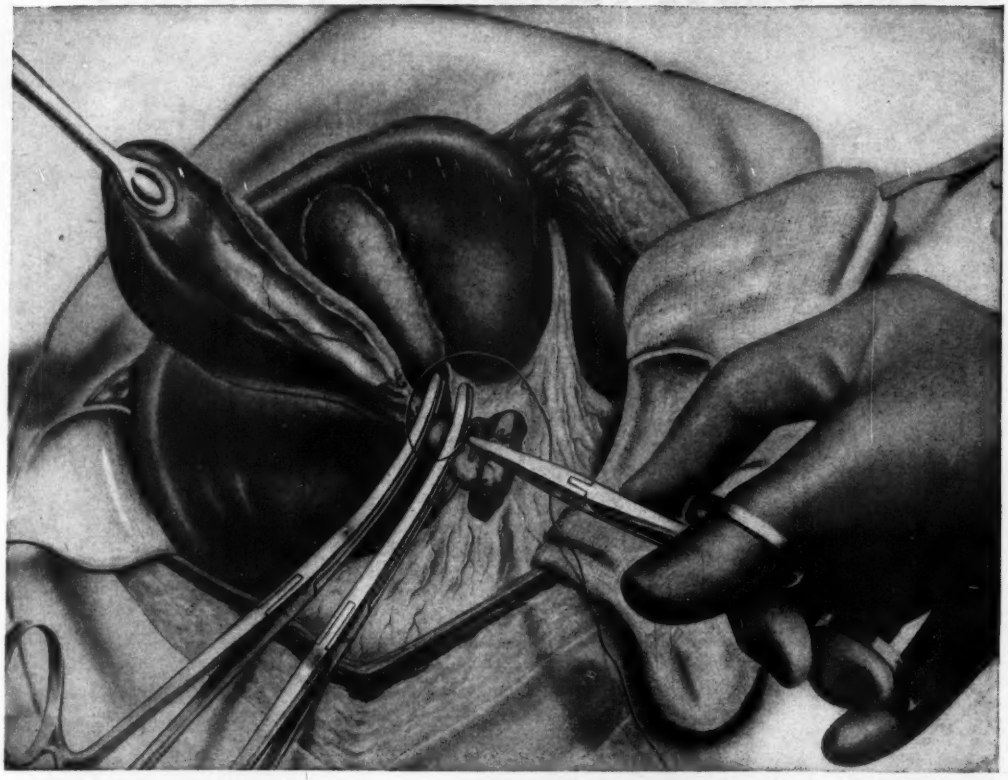
Electrosurgical Units
SW-660 Frequency Controlled Shortwave
X-Ray Specialties

THE LIEBEL-FLARSHEIM CO.

CINCINNATI 2 OHIO

L-F

for this critical ligation "timed-absorption"



The success of a cholecystectomy depends on factors in the patient, in the surgical technic and in the suture material used. In a critical step, such as ligating the cystic duct, the skill of the surgeon must be supported by a dependable ligature, which will not digest prematurely.

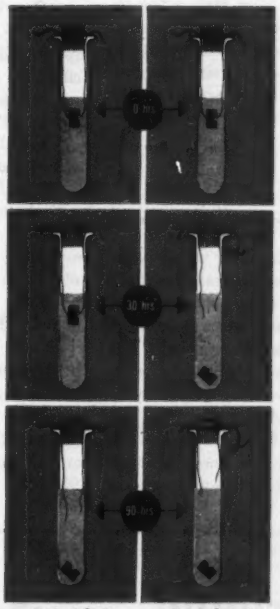
"Timed-absorption" surgical gut assures a predictable digestion rate that can be measured.

By an exclusive improved process, D & G "timed-absorption" surgical gut is accurately tanned in *graded degrees* from the outer surface inward to achieve a more logical absorption curve. Maximum resistance to digestion is assured during *the critical first 4 days* when there is least fibrosis. As fibrosis develops and the need for artificial support lessens, the rate of absorption increases. The ligature on the cystic duct lasts until fibrosis is completed and finally absorbed.

surgical gut sutures will not digest prematurely

90 hours vs. 30 hours

Comparison of D & G "timed-absorption" medium chromic surgical gut suture, size O, with non timed-absorption medium chromic surgical gut suture, size O. Weights are suspended from each in trypsin solution. Note that at the end of 30 hours "timed-absorption" surgical gut remains intact; the weight is still held suspended up to 90 hours. Contrast with non timed-absorption chromic surgical gut suture which has begun to digest and breaks under the slight tension created by the weight at 30 hours. In human tissue all chromic sutures are digested *more slowly*, but the ratio between the two types remains the same.



D & G surgical gut sutures have a special matte finish. They tie readily and do not slip at the knot. Pliability is exceptional and tensile strength, diameter for diameter, is guaranteed to be unexcelled by any other brand.

There is a D & G suture for every surgical purpose, available through responsible surgical supply dealers everywhere.

"timed-absorption" sutures

Davis & Geck, Inc.

a unit of American Cyanamid Company

57 Willoughby Street, Brooklyn 1, N. Y.

Surgeons agree on D & G

Notes About People

(Continued from page 12)

McGill University, Montreal, she was the recipient of a Rockefeller travelling scholarship, in 1944, which permitted her to study hospital and health organizations in many parts of eastern Canada and the United States. For a number of years, Miss Hall acted in a supervisory capacity to hospitals and public health services in Manitoba. As a national advisor on nursing, she has been a representative at several international conferences on nursing problems.

* * * *

Menzie Dyck New Business Manager at the Calgary General Hospital

Menzie Dyck, formerly administrator of the Guelph General Hospital, Guelph, Ont., has been appointed personnel and business administrator of the Calgary General Hospital. Mr. Dyck, who assumed his new duties in June, is a graduate of the University of Saskatchewan and served with the R.C.A.F. during World War II. For several years he was business manager of the Saskatoon City Hospital, Saskatoon, Sask., and, prior to his appointment in Guelph, was assistant to the superintendent at the Kitchener-Waterloo Hospital, Kitchener, Ont.

* * * *

Dr. H. F. Frank, Superintendent Ontario Hospital, Smiths Falls

Dr. H. F. Frank has been appointed superintendent of the Ontario Hospital-School for mentally deficient children, near Smiths Falls, Ont. Born in Ste. Agathe, P.Q., Dr. Frank studied at McGill University, Montreal. Later, he attended Queen's University, Kingston, Ont., where he received his medical degree in 1935. In 1938, he completed a post-graduate course in psychiatry at the University of Toronto. Prior to enlisting with the Royal Canadian Army Medical Corps in 1939, Dr. Frank was a member of the staffs of the Ontario Hospitals at Hamilton and Orillia.

After six years of overseas service, he joined the staff of the Ontario Hospital, Brockville, as clinical director and remained there from 1947 to 1951. Dr. Frank was then appointed assistant superintendent of the Ontario Hospital-School at Orillia, a post he held until his recent appointment. Dr. Frank took over his new duties in May, succeeding Dr. Foster C. Hamilton, the former superintendent.

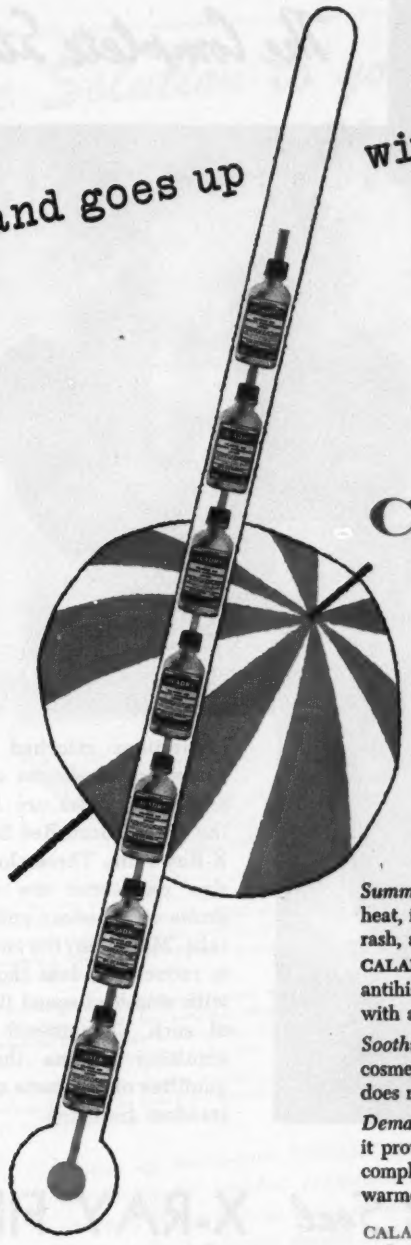
* * * *

Ian Campbell Appointed to Civilian Rehabilitation Services

The Federal Government has announced the appointment of Ian Campbell of Toronto, as National Co-ordinator of Rehabilitation Services for the Civilian Disabled. For some years, Mr. Campbell has been associated with rehabilitation programs carried on by the provincial government of Ontario. At the time of his appointment, he was director of Old Age Assistance for Ontario. In 1947, Mr. Campbell was in charge of the setting up and administration of the Workmen's Compensation Board Convalescent Centre at Malton, Ont. Later, he was appointed first superintendent of the Centre, a post he held until 1951 when he was called upon to direct the old age assistance program. In

(Concluded on page 20)

demand goes up with the thermometer



CALADRYL

TRADE MARK

Calamine and BENADRYL® Hydrochloride Lotion

Summer weather means sunburn, itching, prickly heat, insect bites, poison oak, poison ivy, hives, diaper rash, and minor skin irritations. When these occur, CALADRYL quickly relieves distress through its antihistaminic-antipruritic combination of BENADRYL with a calamine-type lotion base.

Soothing and cooling, CALADRYL is pleasant to use and cosmetically inconspicuous. It won't stain clothing, does not rub off and is easily removed by rinsing.

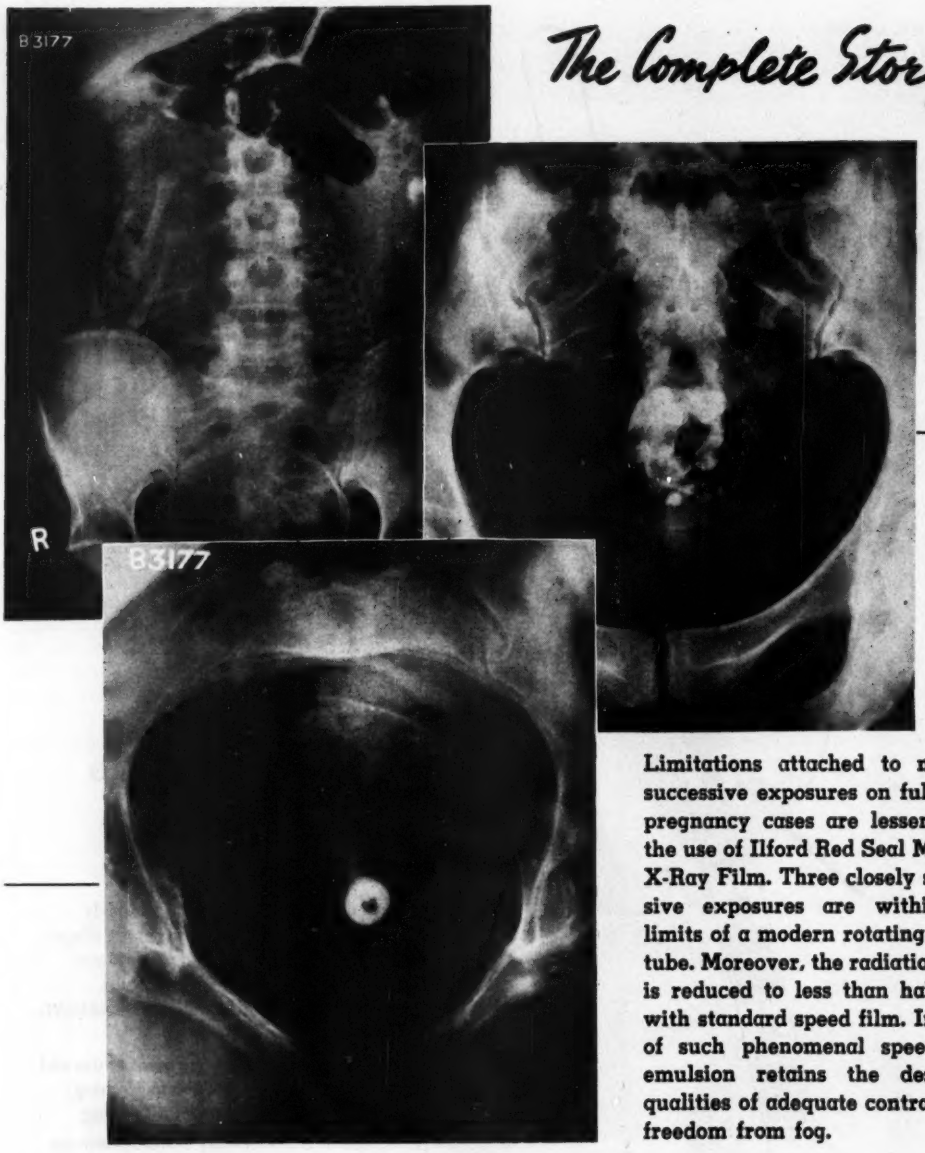
Demand for CALADRYL has steadily climbed because it provides comfort in a wide variety of common skin complaints. This demand is at its peak during the warmer months.

CALADRYL is supplied in 6-ounce bottles, wide-mouthed for easy application.

MEDICAMENTA VERA

Parke, Davis & Company, Ltd.

WALKERVILLE, ONTARIO



The Complete Story

Limitations attached to making successive exposures on full term pregnancy cases are lessened by the use of Ilford Red Seal Medical X-Ray Film. Three closely successive exposures are within the limits of a modern rotating anode tube. Moreover, the radiation dose is reduced to less than half that with standard speed film. In spite of such phenomenal speed, the emulsion retains the desirable qualities of adequate contrast and freedom from fog.

ILFORD *Red Seal* X-RAY FILM

Made in England by
ILFORD LIMITED, ILFORD, LONDON, ENGLAND

and available in Canada from:
FERRANTI ELECTRIC LIMITED
GENERAL ELECTRIC X-RAY CORPORATION LIMITED
PICKER X-RAY OF CANADA LIMITED
PHILIPS INDUSTRIES LIMITED
X-RAY & RADIUM INDUSTRIES LIMITED

The Solution to your

PRE-ADMISSION X-RAY *Problem*

Developed specifically to power pre-admission X-Ray examination units, the Ferranti Photoscope Generator features low initial cost, low operating cost and minimum floor space requirements.

- **Used with a Ferranti-Eureka Rotating Anode Tube designed for this type of service, and the Ferranti 70mm. miniature film photoscope camera, this unit provides *separate* pre-admission X-Ray facilities at a cost only slightly greater than that of accessory equipment placed in the X-Ray Department!**
- **By the use of a really reliable phototimer, the controls have been simplified to a point that the unit may be operated by *untrained* personnel. No additional burden is placed on your X-Ray Technicians.**
- **Space requirements are held to the bare minimum, permitting the unit to be placed in a location convenient to the admitting desk.**

To sum up, the Ferranti PHOTOSCOPE is the only X-Ray unit designed specifically for hospital pre-admission X-Ray examination, providing economy of first cost, economy of operating cost and economy of space. Write today for further details of this important new Ferranti development.

FERRANTI-ELECTRIC LIMITED

TORONTO, ONTARIO

X-RAY DIVISION — CANADIAN MADE X-RAY EQUIPMENT

CSA APPROVED

Notes About People

(Concluded from page 16)

his new position, Mr. Campbell will supervise a long-range rehabilitation program to co-ordinate the efforts of public and private agencies working, throughout Canada, on behalf of disabled persons who have no veteran's or workmen's compensation assistance and can not earn their own living. It has been estimated that there are about 150,000 persons in this category in Canada.

* * * *

Assistant Business Manager Appointed at St. Peter's Infirmary, Hamilton, Ont.

James A. Willan of Sheffield, Eng., has been appointed assistant business manager of St. Peter's Infirmary, Hamilton, Ont. For nearly 20 years, Mr. Willan has been engaged in hospital administration work, where he has gained experience with municipal, public assistant, and voluntary hospitals, as well as with hospital contributory schemes. Prior to his arrival in Canada, he had been senior administrative assistant on the central office staff of The United Sheffield Hospitals, which controls the group of medical undergraduate teaching hospitals in the city of Sheffield.

* * * *

Harold Lindsay

It is with deep regret that word has been received of the sudden death, in June, of Harold Lindsay, F.H.A., secretary, Brockhall Hospital, Langho, England, at the age of 52. During the summer of 1951, Mr. Lindsay spent six weeks in Canada and the United States, where he toured several mental and other hospitals. His keen and enthusiastic interest in all he saw won him a host of friends during his brief visit to this continent.

Born in Haslingden, England, Mr. Lindsay spent the greater part of his hospital career in the service of the former Lancashire Mental Hospitals Board, at Prestwich Mental Hospital, and Brockhall Hospital. He played an important part in the setting up of a separate administration at Brockhall, in 1933, and saw the bed capacity increase from 350 to more than 2,000. In 1948, when the National Health Service came into operation, Mr. Lindsay became Brockhall Hospital's first secretary.

* * * *

New Matron Appointed at South Burnaby Hospital, B.C.

Mrs. A. F. Radcliffe has been appointed matron of the new Burnaby General Hospital, South Burnaby, B.C., which opened recently. Prior to her present appointment, Mrs. Radcliffe was on the staff of the Queen Victoria Hospital, Revelstoke, B.C., for almost nine years.

* * * *

Office Manager Appointed

William Ebert of Port Colborne, Ont., has been appointed office manager of the Port Colborne General Hospital. Mr. Ebert recently graduated from McMaster University, Hamilton, Ont., with honours in political economy.

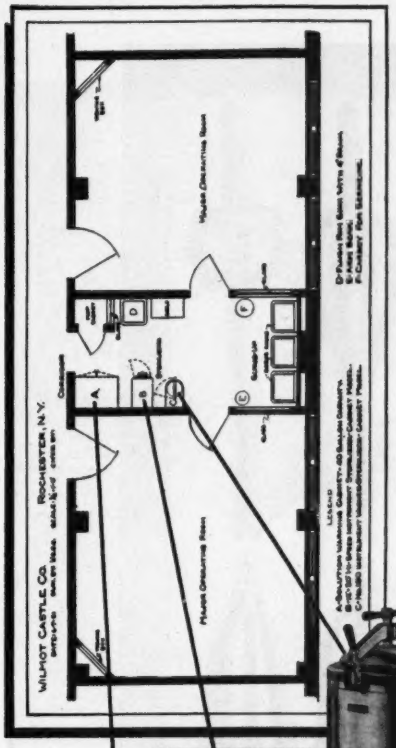
Organization—

for greater O.R. efficiency

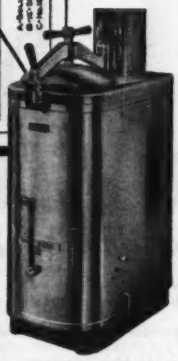
Castle
SUB-STERILIZER ROOM PLANNING

in its advanced concept, now incorporates two important provisions that mean—

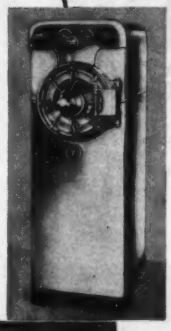
1. **unauthorized traffic being diverted from the surgery.**
2. **minimal sterilizing facilities, adequate for all routine and emergency needs.**



We at Castle believe that every hospital administrator, operating room supervisor and hospital architect will be vitally interested in this modern approach to sub-sterilizer room planning. Note the specimen blueprint of one of the world's most publicized institutions . . . Castle equipped!



STERILIZERS LIMITED TO ONLY 3 ESSENTIAL UNITS

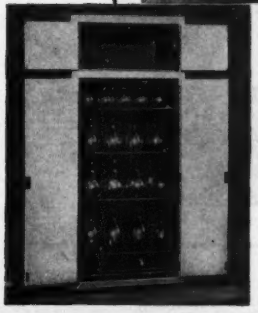


● Pressure Instrument Washer Sterilizer

Washes instruments more thoroughly — faster. *Sterilizes* and *dries* instruments for immediate use or storage . . . all in a single operation within 10-12 minutes.

● Hi-Speed Emergency Sterilizer

For routine sterilization or fast emergency service as the name implies. Soiled or contaminated instrument can be made bacteriologically safe in 5 minutes.



● Warming Cabinet

Precision built for temperature control of flasked sterile water, parenteral solutions, blankets and other supplies normally sterilized in the Central Sterile Supply.

WRITE TODAY for detailed information and benefit through our gratis Planning service

WILMOT CASTLE COMPANY
1176 University Ave. Rochester 7, N.Y.

THE STEVENS COMPANIES
TORONTO CALGARY
WINNIPEG VANCOUVER

Castle

CASGRAIN & CHARBONNEAU, LTD.,
MONTREAL

Abbott's COMPLETE I.V. Equipment

for every routine or emergency procedure

COLLECTING AND PRESERVING BLOOD

For Vacuum Collection:

ABBO-VAC®—A-C-D Solution, U.S.P. (N.I.H. Formula B), in Universal bottles, 500- and 250-cc. sizes. Blood is drawn directly into container by vacuum. Available with sterile, disposable Blood Donor Set. Abbo-vac container also available with Sodium Citrate 4% Solution in 500-cc. size.

For Gravity Collection:

NON-VAC®—A-C-D Solution, U.S.P. (N.I.H. Formula B), in Universal bottles, 500- and 250-cc. sizes. Blood is drawn directly into container (closed technique) by gravity. Available with Donopak® 24 and 48, with or without attached, sterile, disposable needles.

Abbott A-C-D Blood Container—A-C-D Solution, U.S.P. (N.I.H. Formula B), in the familiar conical-shaped Abbott intravenous bottles, 500- and 250-cc. sizes. Blood is drawn (closed technique) directly into container by gravity. Also available with Donopak 24 and 48, with or without disposable needles. Designed for exclusive use with Abbott I.V. equipment.

For Storing Plasma:

Evacuated Empty Plasma Containers—Sterile evacuated 500- and 250-cc. Universal bottles for storing, transporting and administering plasma or serum.

ADMINISTERING BLOOD and or SOLUTIONS

Blood Recipient Set—Sterile, disposable, ready-to-use plug-in set for administering blood from any Universal bottle or Abbott conical-shaped bottle. Has flexible plastic filter chamber.

VENOPAK®—Abbott's sterile, disposable venoclysis unit for the administration of all intravenous solutions. Converts readily to a blood recipient set with a special, disposable blood filter. For use exclusively with Abbott conical-shaped bottles.

(Series Hookup)

Secondary Recipient Set—A unique, disposable unit with a built-in, flexible drip chamber and filter. Designed to plug into any Universal blood bottle and to connect with Abbott's VENOPAK dispensing cap. Allows changeover from saline to blood in a matter of moments, without removing needle from vein.

Secondary VENOPAK—Designed for the continuous administration of fluids in the series hookup with VENOPAK. Plastic, disposable, with a screw-on dispensing cap.

ADMINISTERING FLUIDS SUBCUTANEOUSLY

SUB-Q-PAK®—A completely disposable, preassembled hypodermoclysis unit with plastic Y tube for administration of fluids subcutaneously.

ADMINISTERING PENTOTHAL® SODIUM

VENOTUBE®—Length of plastic tubing with attached male and female Luer adapters and pinch clamp. Allows anesthesiologist to keep syringes off the patient's arm. Pinch clamp offers additional factor of safety.

*Trade mark

NEW

Flexible plastic filter chamber . . . solves clogging problem

YOU'VE seen it happen time and time again. And, frequently, during an emergency, life-saving procedure. The filter drip canula or the blood filter clogs. Usually, the transfusion must be interrupted, the entire equipment torn down, reassembled and a new venipuncture made.

Imagine, then, the possibilities of a *flexible* drip chamber to solve this problem—just squeeze the plastic chamber several times and the blood unclogs. That is one important feature of Abbott's new, revolutionary Blood Recipient Set.

The Blood Recipient Set has another distinct advantage. Its plug-in tip is a metal, needle-sharp, pre-straining canula, which can be aseptically inserted, without pre-perforating, through the stopper of any Universal blood container. The entire set is sterile, pyrogen-free, ready-for-use as it comes in a single package—and it is completely disposable.

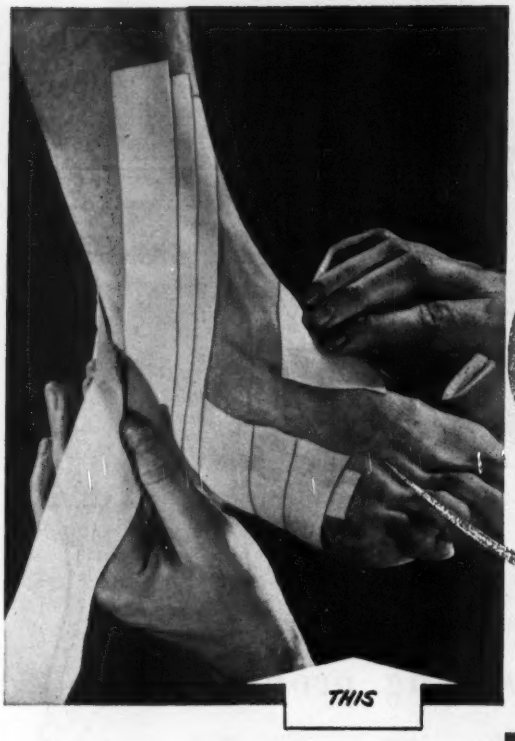
Ask your Abbott representative for a demonstration of this newest innovation in blood transfusing equipment. Or write us direct,

ABBOTT LABORATORIES LIMITED • MONTREAL

Abbott

Investigate the complete

ABBOTT I.V. LINE



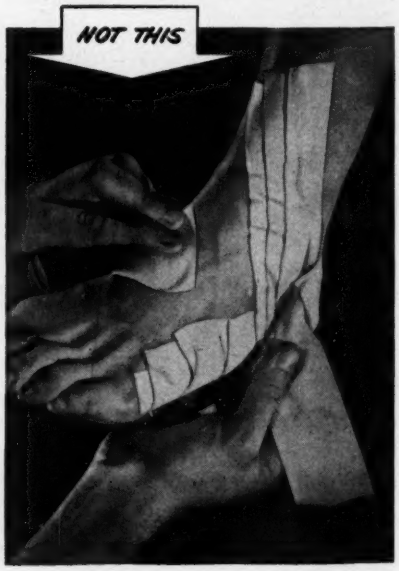
Are You Using the NEW ADHESIVE?

With this new Curity adhesive, smooth, fast, wrinkle-free taping is assured . . . a special cloth backing greatly reduces any wrinkling. And a new adhesive mass gives *added* sticking quality.

The technicians at Curity's laboratories have worked constantly to develop this new adhesive. There have been no restrictions. The result —the finest adhesive modern science can produce.

Prepared from a completely new formula, by Curity laboratory technicians, this new Curity adhesive causes even less skin irritation than the regular Curity brand formerly produced.

This new Curity adhesive costs no more than the Curity adhesive you used before.

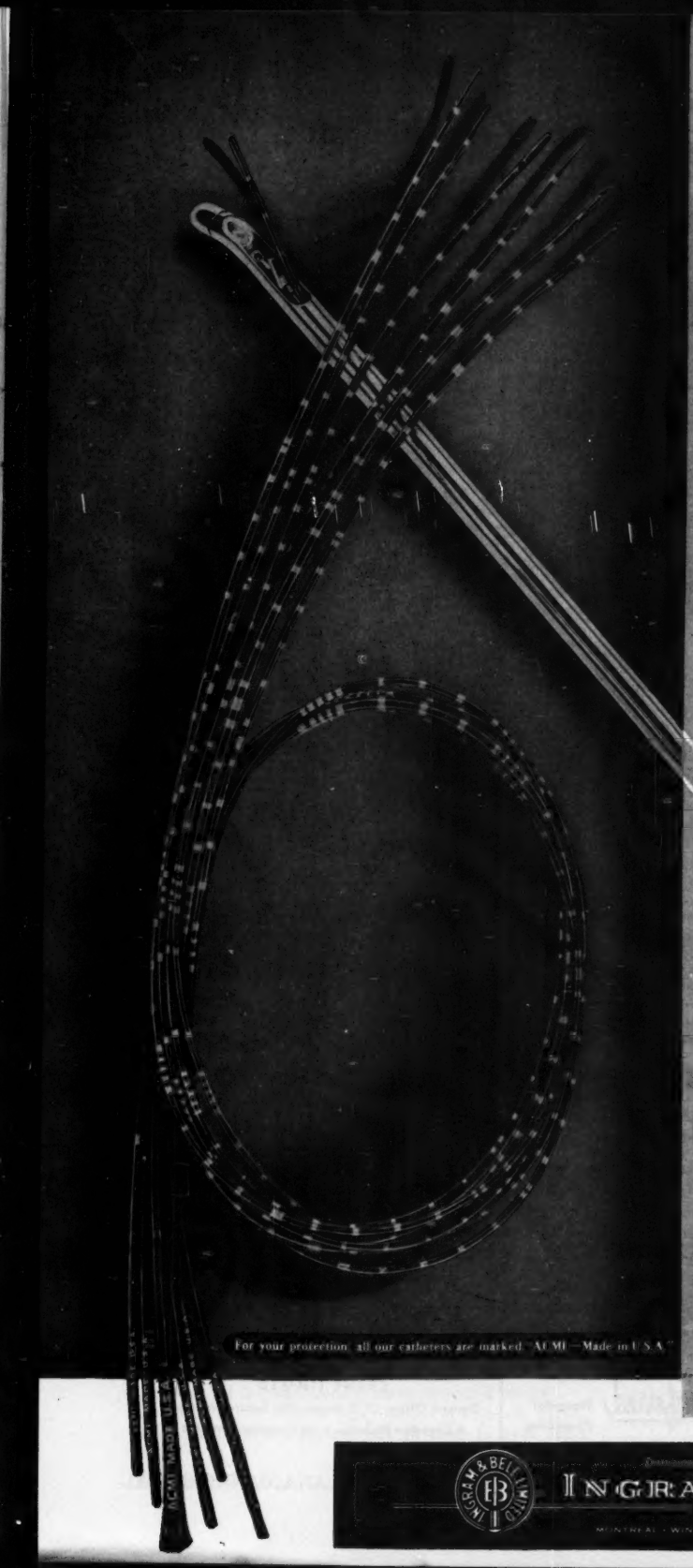


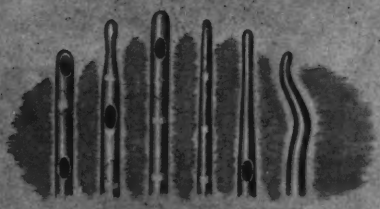
Curity
TRADE MARK

ADHESIVE

BAUER & BLACK

DIVISION OF THE KENDALL COMPANY
(CANADA) LIMITED





ACMI
Woven Ureteral Catheters

Serve Better
because they're
Made Better

QUALITY OF CONSTRUCTION is never more essential for flawless performance than in ureteral catheters. Meticulous urologists prefer ACMI woven catheters because of their . . .

Physical Perfection: They're nylon woven to prevent moisture absorption that might constrict the lumen; and finished with a special baked-in resin coating that assures smooth symmetry from end-to-end, and imperviousness to body acids and salts. Eyes are woven to proper shape and proportion. Boiling or autoclaving will not destroy their original properties. X-ray opaque material is evenly distributed. The result is—

Flawless Performance: ACMI Catheters can be counted on for constant, rapid drainage. They have just the right flexibility; and their slippery surface when moist permits ready introduction. Graduation markings are accurate and clearly visible through the cystoscope.

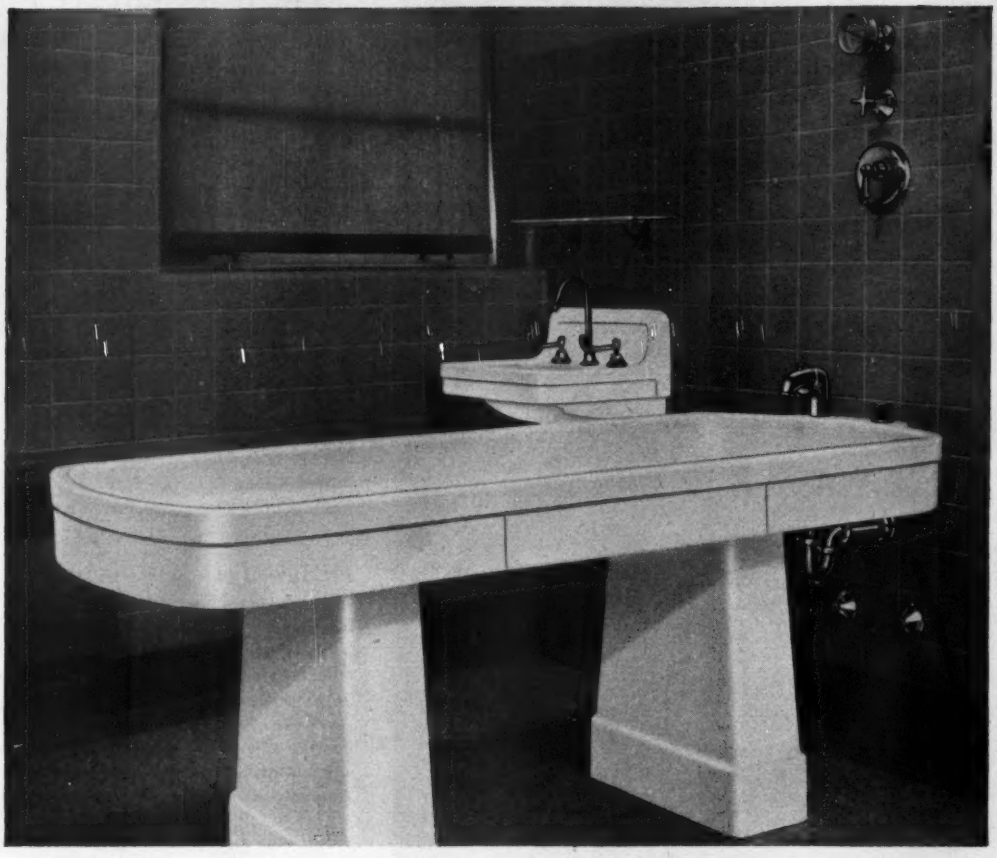
ACMI Catheters are precise in size (with size markings clearly printed); and are available in X-ray, non X-ray, graduated and non-graduated styles; and with a variety of tips, including whistle, round, olive, and Garceau tapered tips.

AMERICAN CYSTOSCOPE MAKERS, INC.
1241 LAFAYETTE AVENUE • NEW YORK 59, N.Y.

First in Cystoscopes — First in Catheters

Distributors in Canada exclusively for
INGRAM & BELL
LIMITED
MONTREAL • WINNIPEG • CALGARY • VANCOUVER

buy Duraclay



ABOVE: Crane Duraclay Emergency Bath.
IN BACKGROUND: Crane Norwich Lavatory, of vitreous china.

for durability and long service...

Resists abrasion, acid, stain and thermal shock

... there's nothing like it. This specially developed vitreous glazed earthenware surpasses the most rigid tests.

For example: Duraclay is impervious to acids ... stains of all kinds are quickly removed with a damp cloth. Duraclay resists thermal shock ... extremes of temperature cannot affect the smooth, hard glaze. Duraclay defies abrasion ... even coarse scouring cleansers leave no mark.

See your Crane Catalogue ADM-8010 "Plumbing Fixtures for Hospitals and Clinics" or ask your Crane Branch, wholesaler or plumbing contractor.

T-5206

CRANE the *preferred* Hospital Plumbing

CRANE LIMITED
General Office: 1170 Beaver Hall Square, Montreal
6 Canadian Factories • 18 Canadian Branches

L. O. Bradley, M.D., Editor

THE CANADIAN HOSPITAL

Toronto, July, 1952 Vol. 29 No. 7

Obiter Dicta

Good Public and Press Relations Stressed at C.M.A. Convention

THE admission of the press to the general council meetings of the Canadian Medical Association, held this year at Banff, Alta. (see page 50), plus the addition of a very successful panel discussion on public relations, were both eventful "firsts", which were indicative of a new C.M.A. policy. These were forward steps which will do much to strengthen the relationship, generally, between the public and the medical profession and, individually, between the patient and his doctor.

Good press coverage, for the first time, carried the careful discussions and deliberations of this professional body to the general public. The keen interest of doctors, individually and collectively, in providing better medical care to the people of Canada was shown clearly in the newspaper reports. These will surely do much to enlighten the readers and to enhance the standing of the profession in the community.

At the general council meeting and during the panel discussions, it was evident that a mutual understanding and trust between the press (which is an important instrument in a program of public relations) and the profession was desirable and necessary. Only through the freer communication of information, both to and from the public and the medical professon, could the needs of each party be known, duly considered, and solved to the satisfaction of both.

In following the lead of the hospital field in a program of public relations, the C.M.A. makes possible a wider front for such a program. Hospitals have often been handicapped in explaining their services to the community because the doctor, fearing what his own confrères may think, has been over-cautious and, in some instances, evasive. Of course, this attitude will not change overnight nor would that be desirable for it could produce many unwanted results.

Hospital and medical organizations at all levels, particularly at the local level, can now sit down to work out a practical, positive program for good public relations. As it unfolds, the medical profession and the hospital field may expect a better understanding of their problems and needs by the general public and, conversely, the individual citizen will find that his medical needs will be met to his satisfaction.

Promoting Better Relationships Between Medical Staff and Administration

THE MEDICAL staff in its hospital setting will be given major emphasis in the August issue of *The Canadian Hospital* which will feature a symposium on this subject. We hope that members of the medical staff will see this issue because notwithstanding the fact that medical practice in hospitals is a continuous favourite at hospital meetings, very little of the benefit derived from such discussion seems to reach the doctors themselves.

In the study carried out in 1945-46 by Dr. Charles E. Prall of the Joint Commission on Education*, it was found that working with the medical staff was a major problem for 20 per cent of administrators. It was the top problem in most situations. However, it is reasonable to believe that when each party becomes more familiar with the thinking of the other, many of the problems will resolve themselves.

Each administrator may contribute to this millenium by making more information on medical staff and hospital relationships available. The article in this issue by Dr. G. E. Chalmers on medical staff by-laws (see page 41) and the more comprehensive treatment of medical practice

**The results of this study are found in "Problems of Hospital Administration", published by the Physicians Record Company, Chicago, Ill., 1948. The Joint Commission on Education was sponsored by the American College of Hospital Administrators and the American Hospital Association.*

in hospitals in the August issue will serve as an excellent first step in the right direction.

Providing Public Health Facilities in Hospitals

IN RECENT years it has been stated repeatedly that space should be provided for the public health services of the community within or adjacent to the local hospital. With some exceptions in certain provinces, this has happened so infrequently that the concept should be re-examined to see if it was sound in the first place.

Medical schools are beginning to emphasize, in their teachings, an integration and fusion of the preventive and curative practice of medicine. Yet, when the young graduate goes out into the world, there is a clear cut physical, functional, and organizational separation of these aspects of medicine. Hospitals and public health departments carry on independently and, oft times, unaware of each other's activities.

The same situation holds for schools of nursing, where the current curriculum stresses integration of preventive and curative factors and is supplemented with work experience in a public health agency. But, in the actual working situation, the public health nurse and the hospital nurse seldom come into contact.

Recent studies suggest that the next effective step in public health practice will be to increase and extend the participation of the general practitioner. Since the practising physician now spends many hours of each day in the hospital, the presence of public health staff in the same area would seem to be an excellent means of hastening the trend.

There is no doubt that the main deterrent to this concept has been the wariness of the two major parties involved—hospital boards and public health officials. Hospital boards have looked at the short-term difficulty of raising more capital funds to provide the extra facilities rather than the long-term advantages that would accrue to the community from closer co-ordination and co-operation. Public health officials, by and large, have paid only lip service to this concept and as a result have little to show in the way of modern facilities. The opportunity to provide leadership in the co-ordination of all health facilities has not been grasped.

An increasing number of our health problems directly concern both of these community services, *e.g.*, long-term illness, home care programs, visiting nursing programs, rehabilitation services, communicable diseases, training of personnel, laboratory services, and so on. If facilities and programs are duplicated, we may expect that questions will be asked from outside the health field. In the matter of sound long-term development, much more interest and activity is needed at the local level. Growth from the local level will be healthier than suggestions or directions from higher levels of authority.

"Don't be an Ash"!

LAST August, in these columns, we called upon all good maintenance men to come to the aid of the hospital. We do it again now with special reference to fire protection. For each ounce of fire prevention taken now, we may expect fewer fires and fewer losses in lives, buildings, and equipment.

Watch our August issue for an article on this subject and remember that to-morrow's fires can be fought today.

Courtesy of Canadian Pacific Railway

A group of majestic trees in Stanley Park, Vancouver, B.C.

The Hospital's Obligation to

The Ambulatory Patient

Donald M. Cox, F.C.I.,
Assistant Commissioner Hospital Services and Chief Inspector of Hospitals, B.C. Hospital Insurance Service, Victoria, B.C.

WE have only to review the plans of hospitals built twenty-five or more years ago to realize that the majority of hospitals then recognized only dimly their obligation to the ambulatory patient.

Such recognition as did exist was slanted largely to the needs of two classes:

(1) Indigents who went to outpatient departments for diagnostic and treatment services normally furnished to self-pay patients in physicians' offices.

(2) Accident cases not requiring bed care but brought to the hospital for treatment of their injuries.

Ambulatory In-Patients

Little thought was given to the needs of the ambulatory in-patient, and understandably so, since the proper place for surgical, maternity, and the majority of medical patients was considered to be flat in bed. Normally, the date of discharge from hospital could be fairly accurately gauged from the date that the patient was allowed to be up. It was not unusual to observe a patient after ten or fifteen days in bed tottering hesitatingly down the corridor, supported by a nurse, and announcing with a mixture of apprehension and pride that he "guessed he'd be going home tomorrow or the next day." True, there were patients, both medical and surgical, whose condition permitted them to be up and about during the day but, by and large, their ambulations, which often took them into forbidden areas, were regarded more as a necessary nuisance than a service challenge. Fortunately, the reaction of hospital personnel was not usually as critical as that of the army hospital nurse who, in reviewing the patient list for the benefit of her relief nurse, warned: "and these are the dangerous cases — they're almost well"!

An address presented at a sectional meeting of the American College of Surgeons held in Vancouver, B.C., April, 1952.

The increasing appreciation of service obligations to the ambulatory in-patient has been inspired by advances in medical care. The almost universally approved concept of early ambulation has made available, to the in-patient, avenues of tangible and intangible service benefits that he could previously enjoy only very moderately, if at all.

Undoubtedly the stress of war did much to further early ambulation and ambulatory services. This is not surprising, for war has many times provided a challenge and an opportunity which medical science has risen to meet. Hippocrates said: "War is the only proper school for the surgeon". Battle casualties among far-flung Roman legions and injuries to gladiators in combat paved the way for advances in surgery in Roman times.

It is true that shortage of hospital beds and the financial strain of greatly increased hospital costs on the patient or the paying agency makes it imperative to utilize to the utmost the possibilities inherent in ambulation to shorten the duration of hospital stay. Since this objective, if attained, is beneficial to the patients either collectively or individually, it is a commendable service aim.

Donald M. Cox.

Hospital Plans

To return to hospital plans for the care of the ambulatory in-patient, let us look first at the nursing units. Toilets, wash basins, and baths were once incorporated only in deluxe private rooms. Now the first two at least are considered to be almost a "must" for all patients' rooms. It might be argued that such installations are designed to save nursing time rather than as a service element. Undoubtedly time-saving is a factor that bulks large in hospital planning; but few indeed would fail to admit the benefits of making available to the patient as much as possible of the personal privacy that he can enjoy in his own home.

In new hospitals, treatment and examining rooms are larger, more conveniently located, and better equipped. The dressing and medication cart will go less often to the patient, and the patient will go more frequently under his own power to the examining and treatment room where doctors and nurses can better assess and serve his needs than they can within the limitations of the ward.

Up-patients' dining rooms located adjacent to ward kitchens, or food service areas will become more and more a feature of hospital planning. No one will overlook the possibility of economies through more centralized food distribution, although the real objectives of such planning will be better service to the patient by dining arrangements that resemble as closely as possible those he enjoys in everyday life.

Sunrooms have long been considered

an essential feature of hospital planning. Frequently they were fitted with signal outlets just in case pressure of admissions necessitated their temporary use as patients' rooms, which it usually did. I predict that the pressure for space for the ambulatory patient will result in the "rescue" of many sunrooms from their lifetime of temporary service as patients' rooms. Newer plans will show a greater allocation of space to lounge and recreational areas and a marked increase in constructive planning of patient activities during up-hours by a close tie-in with physiotherapy and occupational therapy services.

Few hospital administrators, even twenty years ago, visioned the tremendous development in physical medicine that we now accept as commonplace. It is quite evident, however, that this development was concurrent with early ambulation and the vastly increased mobility of the in-patient.

Many hospitals not presently planning new construction or extensive renovations are desperately concerned with the problem of finding sufficient suitable space for physiotherapy. Unfortunately, some have found it necessary to split up physiotherapy services and locate them wherever a bit of space could be found in the hospital. Such dispersal of facilities is not good, and there seems little doubt that scattered arrangements will prove even less satisfactory in the future.

If the ambulatory patient is to go frequently to the physiotherapy department it is obvious that it must be located on the regular line of traffic so that he can readily do so. A location, necessitating excessive guidance and assistance to reach, is certain to detract from the value of the service.

New hospital plans show a very obvious realization of the necessity of designing physiotherapy layouts with muscle training and therapeutic exercises, and other services that can be readily utilized by ambulatory patients. Establishing departments of physical medicine, which merge under specialized medical direction the physiotherapy and occupational therapy services, has been a logical step for large hospitals. The dangers of physiotherapy and occupational therapy projects being undertaken without specific approval and regular review by the physician-in-charge become much more evident when related to the ambulatory patient who may readily overestimate his own capacity. At one time in some hospitals, the operation of occupational therapy projects (or diversional activities) was undertaken by volunteer workers. There is still a splendid field for voluntary effort in providing equipment and assistance in non-technical staffing, but few hospitals fail to realize the essentiality of adequate medical direction, trained therapists' services, and systematic assignment of projects by medical prescription and review of progress records.

Rooming-in Maternity Care

Few abrupt changes in nursing procedures blend as naturally with early ambulation as does the trend towards rooming-in maternity care.

The extremely arduous nature of farm life during the early years of this century and the relatively large farm families prompted more than one woman to remark that the only time she had a real rest was when she was confined. Mechanical equipment in the home, vastly improved transportation, and availability of prepared foodstuffs have added materially to the leisure time of the average housewife, with the result that she does not settle down too readily to even the present relatively short hospital stay. Early ambulation has, in many instances, contributed to rather than decreased the boredom of the new mother, as it enables her to be out of bed and yet gives her no opportunity to gratify her intense desire to care for her child. The possibility of allowing the young mother those beneficial activities and, at the same time, helping her to learn the best methods of caring for her baby under expert guidance, has been the deciding factor for more than one hospital in instituting a rooming-in service in the maternity section.

At the Jefferson College Hospital, Philadelphia, mothers have a choice of rooming-in or conventional nursery services. Ward arrangements are such that the ambulant mother can, under proper supervision, attend to many of her baby's needs. If she prefers to have the baby with her only during the part of the day when she is up and about, the bassinet may be returned to the nursery at other times. Rooms are equipped with basins and mixing spigots with elbow control to enable the mother to wash up before handling her baby. Floor nurses on nursery duty dress the cord, weight and inspect the baby, and assist the mother in its care. Sterile supplies are drawn from a ward carriage maintained for that purpose. Obviously no hard and fast rule could be established for rooming-in service. It could be quite suitable for one hospital and entirely unsatisfactory for another.

New Equipment

Hospital suppliers, eager to do their part to assist in the care of the ambulatory patient, are coming up with many devices to appeal to him, or to hospital staffs, or to both. The adjustable-height bed, for example, enables the bed, by the mere pushing of a button, to be lowered to home height when the patient gets in or out and returned again to hospital height for nursing care.

I was never greatly concerned about the height of a hospital bed until I had a session as a bed patient. I looked at the floor far below me and wondered how I could ever get out and in unassisted — and the limitations of the average hospital gown do not make such a climb any more appealing, even with the assistance of a nurse.

Chronic Care

My remarks have been slanted largely to the acute rather than the chronic hospital. However, the service possibilities of ambulation are equally great, and the ultimate benefits even greater, in the long-term hospital. Several years ago during a study of chronic care, I visited the St. Barnabas Hospital in New York City. While I was waiting for Dr. Merrill, the superintendent, an old man in a wheelchair came along. He asked me to help him find a phone number. He couldn't see to read the fine print, and I knew nothing about New York, but eventually we got the Social Security on the phone and he bawled them out severely for not getting his old age pension cheque out on time. Then he exclaimed, "Well, I'll have to hurry back to get lifted into bed before two o'clock" and away he went. Intrigued by his statement, I spoke to Dr. Merrill, who explained that the patient was lifted into his wheelchair every morning at about ten o'clock. He went to the washroom to wash and shave, had his dinner in a dining room designed for wheelchairs, and got around the hospital pretty readily. If he had been allowed to lie in bed for a few weeks

1952 Class in Hospital Administration at U. of T.

The fifth class enrolled in the post-graduate course in hospital administration at the University of Toronto has completed the nine months' period of academic work and now begins the second year of training as administrative residents at various hospitals.

Top row, left to right: Kenneth C. Temple, who goes to Toronto East General and Orthopaedic Hospital, Toronto; Norman K. Barr, to Royal Jubilee Hospital, Victoria, B.C.; J. Douglas McMillan, Regina General Hospital, Regina, Sask.; Kerle G. Palin, Kingston General Hospital, Kingston, Ont.; John Thompson, M.D., Royal Alexandra Hospital, Edmonton; Stanley D. Krawchuk, St. Mary's Hospital, Montreal.

Second row: Douglas M. McNabb, Vancouver General Hospital, Vancouver, B.C.; Elmer W. Roeder, Kitchener-Waterloo Hospital, Kitchener, Ont.; J. Sydney Renton, Victoria Hospital, London, Ont.; Philip A. Sheridan, Toronto Western Hospital, Toronto; Omer H. Clusiau, Hamilton General Hospital, Hamilton, Ont.

Front row: D. M. MacIntyre, Assistant Professor; Harvey Agnew, M.D., F.C.H.A., Professor of Hospital Administration; Miss Eugenie Stuart, M.S.H.A., Assistant Professor; and L. O. Bradley, M.D., Associate Professor.

he would never have been able to use his wheelchair again. It would have been less costly to have cared for him as a bed patient, but, thank God, the hospital well recognized its obligation to keep him mobile, even if he could not be kept on his feet.

Out-Patients

Let us now review briefly the case of the ambulatory patient who lives away from the hospital but goes there for diagnostic or treatment services. As I intimated earlier, planned facilities for such patients were frequently confined to out-patient departments where physicians and hospitals pooled their efforts to care for the sick poor who lacked means to pay for those services, or at least could make only a token payment.

Well within the recollection of many, X-ray was in its infancy and laboratory procedures were confined to a few relatively simple tests. The practising physician then could and did undertake a large proportion of his diagnostic work in his own office, just as he did treatments that did not require admission to hospital.

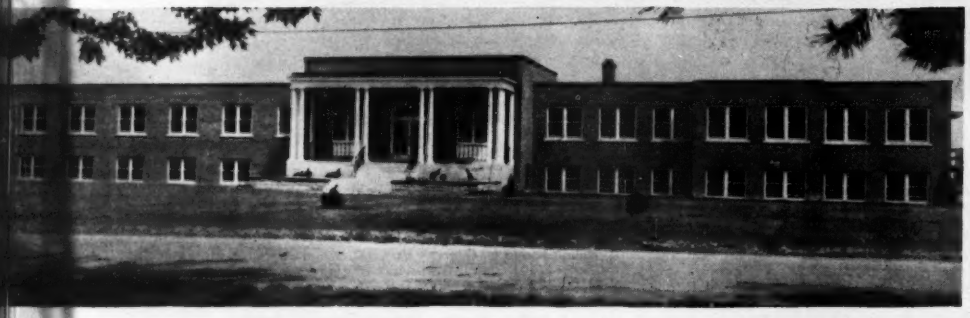
Not infrequently the private physician found his office time so taken up with visits from indigent patients that his earning power was sadly impaired. At the same time, the free patient tended to remain in hospital well beyond the normal discharge date. Certainly there was no financial incentive to induce him to leave and, often, he was fearful that he might not be able to get proper after-care when he went home.

The establishment of the out-patient department was a logical development. It enabled the hospital to press for discharge of the indigent patient as soon as he no longer needed to be in hospital, since facilities for further care were readily available. It enabled the physician to participate in the free service of the out-patient department and still have a much greater portion of office time available for paying patients.

Advances in medical science have brought to bear on disease an array of

(Continued on page 66)

Niagara Cottage Hospital



A glimpse inside the graceful entrance.

Chester C. Woods,
Architect,
Toronto, Ontario.

A BLEND of modern efficiency and gracious colonial architecture is the 27-bed Niagara Cottage Hospital, situated at Niagara-on-the-Lake, Ont. It was officially opened in May, 1951, as the triumphant conclusion of a community-wide campaign to replace the former, outmoded, 10-bed hospital which had served the area since the 1920's. The new, white-pillared, brick and concrete building has been constructed in a style appropriate to this picturesque community with its historical background relating, notably, to the War of 1812. It has a lovely setting amidst well landscaped green lawns.

The hospital is constructed in the form of a "T" and is one-storey in height. It has an attractive entrance

which features Italian marble on the inside. To the left of the entrance is a comfortable waiting room with furniture in natural and green leather trim. On the right are the business offices, a nurses' station, and the nursery toward the end of the wing. The surgical and obstetrical suites, x-ray, et cetera, are also on this floor as well as the patient's rooms. Service departments, such as dietetic, laboratory, stores, and laundry, et cetera, are on the ground floor. Here there is additional space for "extras", including a room for the women's auxiliary and unfinished areas reserved for future expansion.

Patient Accommodation

Patients are accommodated in eight private rooms, six semi-private rooms, and one three-bed room. There is also a two-bed room which has been designated for children. In the semi-private rooms, each bed may be completely partitioned off by means of a curtain on an overhead rack.

Surgical and Obstetrical Suites

These suites are located in the wing at the rear of the hospital. The surgical suite includes major and emergency operating rooms with a surgeons' scrub-up section. The obstetrical suite contains delivery room, labour room and scrub-up. Completely cut off from the rest of the hospital by double glass doors, the surgical and obstetrical suites have been arranged so that the central sterile supply room and the x-ray department can serve both conveniently. A comfortable doctors' lounge is also located near both suites. Operating rooms are air-conditioned, with shock-proof and explosion-proof light switches, and insulated floors.

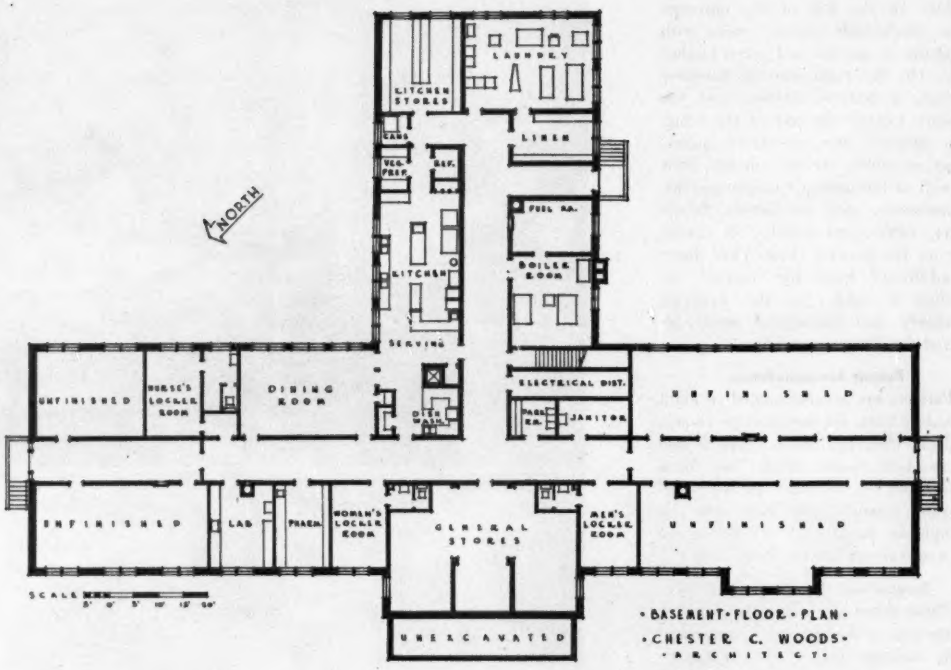
The Nursery

Babies are cared for in the well-equipped nursery which contains nine bassinets, two incubators for premature babies, and a small, separate "suspect" section. It also includes a nurses' work room, doctors' examination and treatment rooms, and a

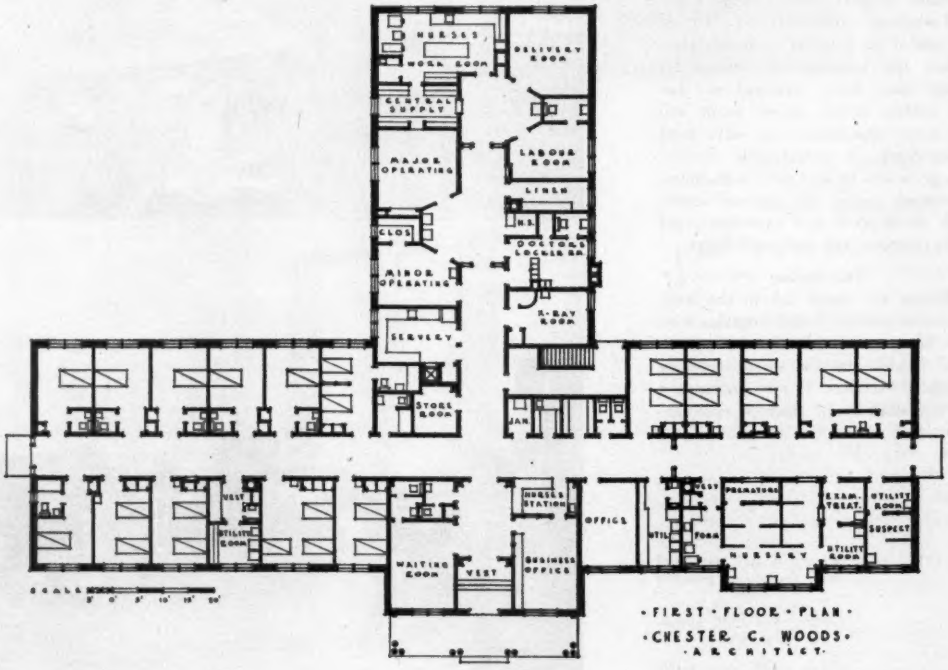
Above: A well furnished and decorated patient's room.

Centre: The main operating room.

Below: The comfortable waiting room.

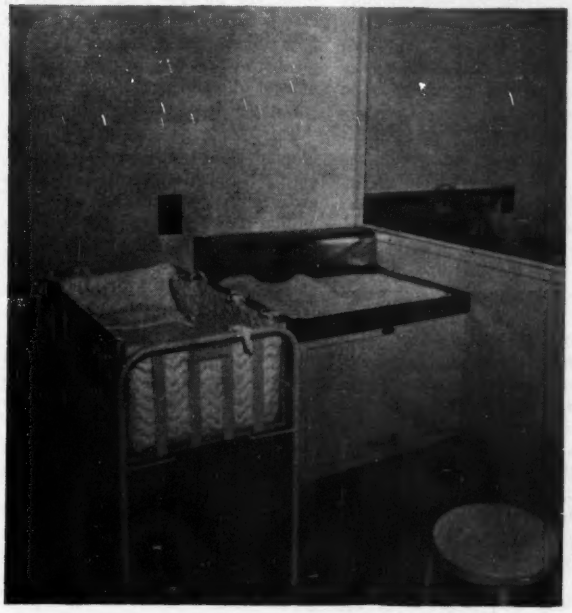


• BASEMENT • FLOOR • PLAN •
• CHESTER C. WOODS •
• ARCHITECT •



• FIRST • FLOOR • PLAN •
• CHESTER C. WOODS •
• ARCHITECT •

section for the preparation and sterilization of formulas. The nursery is well arranged and there is no direct entry into the area, containing the bassinets, from the corridor. The physician enters from the corridor into the examination room where the infant is brought to him.



Dietetic Department

The well-planned kitchen, designed for future expansion, is centrally located for the purpose of providing quick, easy service to the patients as well as to the staff's dining room which is situated next to the serving area. At one end of the rectangular kitchen, there is a walk-in refrigerator, a spacious store-room, and the entrance for receiving supplies. At the opposite end, the serving area and the dish-washing facilities are separated by a dumb-waiter which carries food to the first floor servery.

The Laundry

The laundry and linen storage rooms are arranged to give complete and efficient cleaning, storing, and distributing service for this hospital's bedding and linen. The laundry room is equipped with sorting racks, automatic washing machines, extractor, tumbler dryer, and an electric ironer.

Decoration and Construction

The colonial influence of the architecture has determined the decoration scheme in the interior of the building. This influence is seen throughout, from the comfortable waiting room, which gives an air of serenity with its cool-looking shades, to the pastel-coloured patients' rooms, each distinctive in colonial-patterned chintz drapes. Furniture is styled for comfort and charm. Early Canadiana design is featured in the superintendent's office and furnishings are in mahogany. The nurses' dining room is very attractively decorated in coral tones and has shining metal furniture with coral-coloured leather.

Structurally, the building incorpor-

(Continued on page 92)

Above: One of the nursery cubicles.

Below: A section of the examination room, which is between the nursery proper and the suspect nursery.

A Brief Report on

Hospital Costs

HOSPITAL costs have gone up and hospitals should make no apology for the fact provided they insist upon efficiency, and every economy consistent with good medical care. Hospitals must constantly review their methods in the light of present-day conditions and make adjustments when and where indicated by the advances of medical science and of sound business practices. Economy and efficiency are continuing efforts, requiring the utmost co-operation of our doctors, nurses, and other personnel. Such co-operation has been evident to an even greater degree since our economy and efficiency committee, composed of doctors, nurses, and the administration, first began its weekly meetings in December.

In considering hospital costs one should bear in mind that, generally speaking, there are more dollars with which to pay hospitals bills, that the average length of stay in hospital is much shorter than it was some years ago, that treatment is better and more rapid because of the antibiotics, because of the very frequent use of blood transfusions and oxygen, and because of the progress in surgery whereby very major procedures are now done daily with a very low operative risk.

Serious reflection will soon prove to even the most casual observer that the full control of hospital costs is not within the power of the hospital. We do not entirely dictate the amount of our payroll which accounts for 53 per cent of our expenditures; rather, we must compete with industry and business—often to our disadvantage. Nor do we fully control the cost of the various items of supply and expense which accounts for the remaining 47 per cent of our expenditures. We can, however, and we do rigidly restrict the personnel on our payroll to the least possible number it takes to operate the hospital and we insist, as we should, upon a day's work for a day's pay. With regard to supplies and expense we should and we do exercise strict control to keep such expenditures to an irreducible minimum. This is the first attack on hospital costs.

The second is the importance of providing diagnoses, and even the giving of certain treatments on an ambulatory basis. You will recall that our private and semi-private diagnostic service was established in the Ross Memorial Pavilion in 1948 to provide diagnostic tests and treatments which otherwise would have required admission to hospital. Last year 3,376 patients—an increase of 50 per cent over 1949—availed themselves of this service with more convenience and with less expense to themselves. For example, a blood test for diabetes, an x-ray of the bowel, an electrocardiograph, and basal metabolism test, are a few of the procedures which your doctor can arrange to have done in such a service without admission as an in-patient. Upon appointment, the business man may stop in at the hospital on the way to his office to have his test; if necessary, tests may be done on successive days. Whether it be the busy business man or the busy housewife, in using such a service, the patient has saved a good deal of time and money and, better still, has maintained the normal daily routine of office or home. It should be emphasized that a similar service for those unable to afford private or semi-private rates is available in the out-patient clinics.

A third point is that, once a patient is in hospital, it is the duty of all in attendance upon him to see to it that he does not stay one day longer than is absolutely necessary regardless of his ability, or inability, to pay. There should be no unnecessary tests and no unnecessary delays in the carrying out of diagnostic procedures and treatments. His absolute need of hospital facilities must be the only criterion for determining the exact day of discharge. This goal will be reached the more quickly when this city has adequate accommodation for the mentally ill, those with tuberculosis, the chronically ill, the convalescent, and those in need of proper rehabilitation.

Contrary to some opinions, doctors are very much concerned with hospital costs. Doctors alone decide who shall be admitted to hospitals, how often, and for how long. Doctors, in exercising their prime prerogative for prescribing, set a pattern for the number of personnel required, and the amount of equipment needed, and the hospital must so provide within reason.

The fourth point with regard to hospital costs is the matter of insurance. Hospitalization insurance is growing by rapid strides, with fifty million people in Canada and the United States covered by Blue Cross, and another twenty-five million by commercial insurance. Together they insure one-half of the total population. Great as has been hospitalization insurance's growth it could and should expand a great deal more—and as quickly as possible. One hears too much unjust criticism of hospitalization insurance. It would seem that some people do not consider insurance adequate unless it covers the total cost of every conceivable service. It should be borne in mind that the intent is to provide "disaster" coverage. This means that the insurance will cover the greater part of the cost, leaving to the individual a portion which he normally would be able to carry. If coverage were to include all, premiums would have to be so high as to make such insurance impractical. It has been shown in other places that full coverage for costs of hospitalization has led to abuses in the form of unnecessary admissions and prolonged hospital stay with resulting increase in the total cost of hospitalization.

I repeat, therefore, that there are these four things which the patient, the doctor and the hospital administrator can do to relieve the individual burden of hospital costs:

1. Exercise of efficient and economical hospital administration.
2. Use of ambulatory facilities to a much greater degree.
3. Reduction of the length of hospital stay to the shortest time consistent with safety and avoidance of unnecessary tests and unnecessary delays.
4. Further growth of hospitalization insurance.

From the report of Dr. J. Gilbert Turner, Executive Director, to the Annual Meeting of the Governors of the Royal Victoria Hospital, Montreal, April 16, 1952.

Bigger and Better—

Western Canada Institute

At the opening ceremonies, the Hon. A. D. Turnbull, B. C. Minister of Health and Welfare, addresses the gathering. Seated, left to right, are: Lloyd F. Detwiller, commissioner, B.C.H.I.S.; A. H. J. Swencisky, president, B.C. Hospitals' Association; Dr. G. G. Ferguson, secretary, B.C. Division of the C.M.A.; and Dr. A. C. McGugan, inter-provincial chairman of the Institute.

DURING the week of June 16th, the 7th Western Canada Institute for Hospital Administrators and Trustees provided yet another course of highly satisfactory study, together with relaxation and some entertainment, for representatives from hospitals in the four western provinces. The British Columbia Association of Hospital Auxiliaries held its annual meeting concurrently and its members also attended general sessions of the Institute. Altogether there was a registration of well over 400, this number including students, visitors, exhibitors, and staff. Of these present, 225 students received certificates for full attendance and 78 were able to take only part of the course. After sessions, skies being for the most part clear and sunny, students were able to enjoy strolling about the lawns and gardens of the University of British Columbia — perhaps Canada's most spacious campus.

General sessions were held in the university auditorium, while in the armoury directly across the road, the exhibitors displayed hospital supplies and freely dispensed information and advice. The program provided generous intervals for visiting the exhibits and the crowd moved easily about in the wide aisles. Certain booths were furnished for the use of hospital people — for brief conferences or just resting; while some companies served free fruit juice and hot coffee. There were altogether 44 excellent displays to be examined.

Members of the Hospital Accounting Work Conference proudly display copies of the "Canadian Hospital Accounting Manual." Front row: (left to right), J. A. McGilp, provincial supervisor of hospital administration, Edmonton, Alta.; and R. M. Clements, accounting consultant, Division of Hospital Administration and Standards, Department of Public Health, Regina, Sask. Back row: (left to right), Paul D. Shannon, executive secretary, Associated Hospitals of Manitoba, Winnipeg; and L. A. Yeomans, assistant controller, Hospital Accounting, B.C.H.I.S.

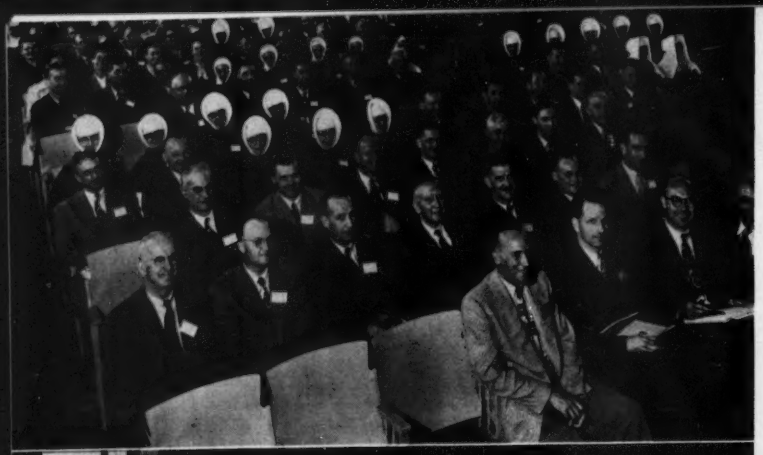
The institute was officially opened on the morning of June 16th, by the President, A. H. J. Swencisky. Musical numbers were provided by St. Paul's Glee Club (student nurses from St. Paul's Hospital School of Nursing), followed by an invocation by Rev. Father J. A. Leahy, Vancouver. Later in the morning, the assembled students were welcomed by the Hon. A. D. Turnbull, Minister of Health and Welfare, Province of British Columbia; by Dr. A. C. McGugan, Inter-Provincial Chairman, Western Canada Institute; by Dr. G. G. Ferguson, Secretary, B.C. Division of the Canadian medical Association; and by Lloyd F. Detwiller, Commissioner, B.C. Hospital Insurance Service.

The Institute then divided for two work conferences which lasted through Monday afternoon and all day Tuesday. While those attending enjoyed and appreciated the highly varied program provided on other days, the conference on the *Canadian Hospital Accounting Manual* and that on nursing administration were outstanding features of this year's Institute. The only complaint of those most interested was that they needed even more time for their discussions.

Conference on CHAM

One hundred and forty-two persons chose to attend the work conference

At the Institute . . .



Enthusiastic and interested delegates gather for one of the many lively sessions of the accounting work conference.

Pausing to chat between sessions are, (left to right), J. M. Morrison, administrator, Royal Inland Hospital, Kamloops, B.C.; J. E. Robinson, Department of Public Health, Regina, Sask.; A. K. McTaggart, superintendent of Brandon General Hospital, Brandon, Man.; and C. E. Barton, assistant superintendent, Regina General Hospital, Regina, Sask.

Four Sisters of St. Ann smile for the camera as they leave the auditorium, left to right: Sr. Mary Annette, Lourdes Hospital, Campbell River, B.C.; Sr. Mary Colombe de Jesus, St. Martin's Hospital, Oliver, B.C.; Sr. Mary Angelus, St. Martin's Hospital, Oliver; and Sr. Mary Barbara, Bulkley Valley District Hospital, Smithers, B.C.

Busy officials take time to pose for a picture. Left to right: Dr. A. C. McGugan of Edmonton; A. W. E. Pitkethley, manager, hospital construction division, B.C.H.I.S.; Mrs. H. C. McPhalen, president, British Columbia Association of Hospital Auxiliaries; Paul D. Shannon of Winnipeg; and Percy Ward, executive secretary, British Columbia Hospitals' Association.

A section of the nursing administration work conference. Front row, left to right: Mrs. R. Tinkers, Vancouver; Miss Evelyn Mallory, U.B.C., faculty; Miss V. Ward, Murrayville, B.C.; Mrs. T. Skillican, Abbottsford, B.C.; Miss E. J. Ellis, Vancouver; Miss J. Mitchell, Vancouver; Miss L. Horwood, U.B.C.; Second row, left to right: Mrs. M. McVeigh, Vancouver; Miss E. Kunderman, Vancouver; Miss E. E. Nordlund, Victoria; Miss L. Brinkman, Cobble Hill, B.C.; Mrs. E. Derrick, New Westminster, B.C.; and Miss E. A. D. Janzow, New Westminster.

Among those in attendance are, left to right: Dr. L. O. Bradley, executive secretary of the Canadian Hospital Council; John M. McIntrye, superintendent, Winnipeg Municipal Hospitals, Winnipeg; Donald M. Cox, assistant commissioner, B.C.H.I.S.; John Smith, Yorkton, Sask., secretary, Saskatchewan Hospital Association; and A. H. J. Swencisky.

Rev. Father J. A. Leahy, S. J., Vancouver, (left), and Father H. Légaré, O.M.I. of Ottawa, attended the busy sessions.

Sr. Mary James, Sr. Mary Ruth, and Sr. M. Alexina (left to right), all of St. Vincent's Hospital, Vancouver, are pictured with (left to right), Lloyd F. Detwiller of Vancouver; Harvey E. Taylor, first vice-president, British Columbia Hospitals' Association; and H. R. Slade, Powell River, B.C.

Pictures by W. O. Cavanagh, Vancouver.

on accounting. After a general historical introduction to CHAM (the *Canadian Hospital Accounting Manual*) this work conference was subdivided into four groups to review the contents of CHAM, chapter by chapter. Students were allocated to the four groups on the basis of each individual's choice and his relative training and experiencing in accounting. Group A, then, became the amateurs, B the bookkeepers, C the cost accountants, and D the future directors.

Four sessions were held by each group. P. D. Shannon of Manitoba reviewed and lead the discussion on accounting principles, L. A. Yeomans of British Columbia handled income and expenditure, John McGilp of Alberta covered receipts and payments, and R. M. Clements of Saskatchewan, director, work conference, reviewed cost analysis, budgeting, and systems.

After the four sessions were finished, the candidates were re-organized into provincial groups for a short discussion on local accounting matters. At the close of the conference, several constructive suggestions were submitted by the candidates and two ballots were taken to determine the group reaction to: first, the work conference; and, secondly, to CHAM.

On the accounting work conference, one ballot was not marked, three candidates felt the sessions were poor, 26 voted fair, 52 good, 50 very good, and 10 excellent. One CHAM ballot was not marked, 1 voted poor, 3 fair, 43 good, 66 very good, and 28, excellent.

Nursing Service Administration

This work conference was held in the new quarters of the University of British Columbia School of Nursing, the Wesbrook Building. The director was Evelyn Mallory, B.Sc., M.A., R.N., Professor and Director of the School of Nursing, University of British Columbia. Those who assisted with planning and conducting the work conference were: Misses L. Horwood, A. Wright, E. Paulson, N. Ward, E. M. Eastley, E. J. Ellis, J. Mitchell, E. Kunderman, E. E. Norlund, L. Brinkman, E. A. D. Janzow, Mrs. T. K. Skillicorn, Mrs. M. McVeigh, and Mrs. E. Derrick. The total enrolment for the conference was 92.

The objectives of those who planned the conference were to provide tools to assist nursing service administrators to solve their problems; to emphasize and illustrate the importance of the effective use of available personnel; and to provide an opportunity for the interchange of ideas in regard to common problems.

Following Miss Mallory's introduction Monday afternoon, the entire conference broke into small groups to become acquainted and to discuss the content of the work book, in which

(Continued on page 68)

Special Meeting of the British Columbia Hospitals' Association

Under the chairmanship of the President, A. H. J. Swencisky, a special general meeting of the British Columbia Hospitals' Association was held on June 21st, at the University of British Columbia, immediately following the Western Canada Institute. Those present numbered 98 and of these 51 were official delegates from their respective hospitals. According to the association's constitution, the annual general meeting must take place in the fall. However, with so many official delegates present for the Institute, it was the consensus of opinion that, for reasons of convenience and economy, a business session should be held at this time. Then, in the fall, it will be necessary only to call a quorum (10 delegates) to approve the business transacted by the larger body in June.

Resolutions

A slate of resolutions were presented for consideration by Harvey E. Taylor, chairman of the Resolutions Committee. The first three expressed appreciation to the press of the province, to the University of British Columbia, and to the exhibitors for their co-operation during the Institute. There was a vote of thanks to the association's auditors for their assistance throughout the year. Other votes of thanks were expressed to the Hon. A. D. Turnbull, Provincial Minister of Health and Welfare; to Lloyd F. Detwiller, Commissioner of B.C. Hospital Insurance; to the Canadian Hospital Council, represented by Dr. L. O. Bradley, Toronto, and Dr. A. C. McGugan, Edmonton, who is chairman of the Institute's co-ordinating committee; to Robert M. Clements of Regina, who directed the work conference on the *Canadian Hospital Accounting Manual;* to Evelyn Mallory, Director of the School of Nursing, U.B.C., and her assistants, who guided the work conference for nurse administrators; to the students of St. Paul's Hospital School of Nursing who provided music for the opening ceremonies of the Institute; and to the British Columbia Association of Hospital Auxiliaries for arranging entertainment during the Institute. These votes of thanks were all approved.

A series of resolutions were then submitted to the Resolutions Committee either by regional councils or individual hospitals, and by the B.C. Hospital Insurance Service. Some of these were not recommended by the Committee. A few were defeated because they were purely local in character and did not concern problems which the association as a whole should consider. Others were tabled for further study.

A final resolution, which was passed almost unanimously, re-affirmed the faith of the association and its support of the British Columbia Hospital Insurance Service.

Certain amendments to the association's by-laws were submitted at this special meeting in order to obtain a general opinion. As they were approved, these amendments will be given final consideration at the fall meeting of the association.

Officers

The meeting concluded with the election of officers which at this time concerned only three offices, that of president, first vice-president, and second vice-president. A. H. J. Swencisky, retained the presidency and Harvey E. Taylor, Port Alberni and J. A. Abrahamson, Revelstoke, were re-elected to the first and second vice-presidencies respectively.

Regional representatives to the Board of Directors will be elected during the summer months, to take office in October. Division representatives, likewise, are to be appointed by their own organizations. —*J.F.*

Medical Staff By-laws for Highest Standards of Patient Care

G. E. Chalmers, M.D., F.A.C.S.,
Chief of the Surgical Service, Victoria Public Hospital, Fredericton, N.B.

THE problem of establishing satisfactory by-laws in a small hospital is a very difficult and complex one. In this article, an attempt will be made to set forth certain proposals which are applicable to hospitals under 200 beds, situated in towns and cities with populations up to 50,000. Hospitals of this size in larger cities are excluded because their problem is entirely different. The majority of these are closed hospitals with specialized departments and high medical standards which make them more easily geared for efficiency.

In hospitals such as those I work in, we are dealing chiefly with general practitioners of various grades of competence and with a few qualified specialists. Most of these hospitals are open and thus it is up to the medical staff to establish their own standards and to enforce them.

Before a medical staff can organize and operate efficiently, certain important factors must be present. The plant or hospital must have:

1. the minimum, at least, of modern equipment;
2. a good administrator, a medical man preferably, (not discounting the excellent work, done by some non-medical men);
3. a good nursing department, well-run by qualified instructors;
4. a friendly and co-operative liaison between various departments;
5. an understanding and co-operative governing board;
6. a medical staff.

The medical staff's efficiency depends a good deal on the type of persons who comprise it. In small hospitals, there must be one or two individuals who are well-trained and not only interested in their own personal work but also in the hospital's work as a whole and in the health of the community. They must be anxious to maintain a high standard of medical care. Without such men to act as leaders, unity of purpose is apt to be lacking among members of the medical staff and numerous complex and conflicting situations can develop.

However, I am not advocating that, in order to achieve efficiency, everything and everybody must be in perfect harmony, with arguments, quarrels, and disagreements completely banished —not at all, for that kind of organization would be dead on its feet. Only when there is honest disagreement (and even quite open conflict at times) within an organization does it move, grow, and develop. This assumes, of course, that conflict is not carried to the point where it interferes with the effectiveness of the organization.

There should be mutual confidence and trust between members of the staff. It is difficult to achieve good organization among persons who dislike or hate each other. There must be good and friendly liaison between the various department heads, the administrator, and nursing superintendent.

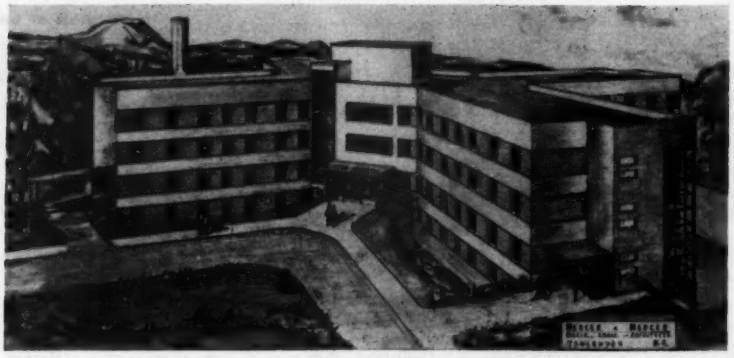
Finally, there must be personal satisfaction in doing the work. If, at a monthly meeting, one heard a report something like this—"no incomplete charts, highest admission record, more x-ray and laboratory examinations, lowest mortality and morbidity rate, no infections, autopsies on all deaths" —then I am sure every staff member would have a wonderful feeling of satisfaction. It is also a great satisfaction to find that after the inspector of the American College of Surgeons has left we find ourselves still on the approved list.

By-laws

The medical staff must draw up its own medical by-laws, rules, and regulations. If you have good medical men you can draw up a good set of by-laws. If this is not the case, the community is going to receive poor medical care. In our hospital, a committee is now working on a revision of the by-laws, rules, and regulations governing the medical staff and I shall refer to this, on occasion. As a member of that committee I find the discussion most interesting. The by-laws had been revised in 1938 and the revisions showed a marked improvement over the previous ones. Since then numerous amendments have been made and it is our job to revise and study them, make new additions, if necessary, and to bring a complete and up-to-date set of by-laws, rules, and regulations to the medical staff. As we reviewed these it was most interesting to note that every revision and amendment made during the years, brought better efficiency and organization and provided better medical care and protection for the patient.

The basic standards of our by-laws are those of the American College of Surgeons and I shall deal with the points that are applicable to improving efficiency in small hospitals. Our staff is divided into honorary, consultant, attending, associate, and courtesy staffs. The attending staff, or active medical staff, is divided into senior attending and junior attending, with a chief of each service. Only the members of the active staff are eligible to vote and hold office. The retiring age is 65 years. Previous to 1938, all appointments were made by seniority. Today our section on promotions is, I think, a standard one in most hospitals. It reads as follows.

An address presented at a sectional meeting of the American College of Surgeons held in Quebec City, P.Q., February, 1952.



Modern New Hospital for Penticton, B.C.

The citizens of Penticton, B.C., are looking forward with pride to the completion of their new hospital, pictured above as an architect's sketch. Of sleek, modern design, this hospital will contain 121 beds and 32 bassinets when completed early in the spring of 1953. Over 20,000 people will be served by this new hospital situated in the largest city of the lovely Okanagan Valley, famous fruit-growing area.

Before the new hospital could become even an architect's sketch, there were long years of planning and hard work. A highly successful and over-subscribed fund-raising campaign was held and the sum of $100,000 was realized. As part of this program, individual donors and communities "adopted" a portion of the hospital and supplied the funds for furnishing and equipping various units.

The architectural firm of Mercer and Mercer, Vancouver, designed the new hospital and James A. Hamilton and Associates were consultants. When equipped and furnished, the building will cost approximately $1,500,000. It replaces the present 69-bed hospital which was established in 1916.

←

"Normally these (appointments) shall not be made on seniority alone but, rather, shall be judged by high professional qualifications and skills, a proven record of co-operation with confrères and the governing body, and a declared intention to assist in raising the standards of the hospital care by adopting a genuine teaching attitude towards the nursing staff and the less experienced members of the medical staff. The assessment of the professional qualifications shall initially be carried out in all instances by the credentials committee. The report and recommendations to the medical staff shall include a statement of the qualifications of those staff members for whom selection for promotion is going to be made."

Previous to 1938, the staff was divided into departments of medicine, surgery, and obstetrics. Today it is as follows:

1. Medicine—general medicine, including cardiology, communicable diseases, dermatology, gastroenterology, neuropsychiatry, metabolism, and paediatrics.
2. General surgery—including orthopaedics (exclusive of fractures), urology, gynaecology, neurosurgery, thoracic surgery, dental, plastic surgery, and physiotherapy.
3. Opthalmology and otorhinolaryngology.
4. Obstetrics.
5. Anaesthesia.
6. Radiology.
7. Pathology.

Assignments to the various divisions of the attending staff are made at the annual meeting and are of one-year's duration. Each service or division nominates its own chief who is responsible to the chief of staff for the functioning of his service and he (chief of staff) shall have general supervision over the clinical work of its members.

Officers and Committees

The officers of the staff are: president, vice-president, and secretary—who also acts as treasurer if there are any funds.

In our hospital, the president of the medical staff is also our chief of staff and it is imperative that he be one of our most capable men and one who holds the respect and confidence of the members. He is also our medical representative on the governing board. Although he is elected for one year it is our policy to keep him in office for two years.

The committees are "standing" and "special". Except for the executive committee, all are appointed by the president. The standing committees are as follows: executive, medical records, credentials, interns, program, library, and pharmacy. Special committees are appointed from time to time as required.

The efficient functioning of the hospital depends a great deal on the individual who is chief of staff and on the chairmen of the various committees. These positions should be filled by men whom the medical staff know will do a good job and who will give time and thought to their duties. The duties of the officers of the medical staff and of all the standing committees should be clearly defined. The duties of the chief of staff are also very important. They are well summed up by the committee of the Ontario Medical Association and are as follows:

(Continued on page 74)

Le Coeur de l'Hopital

Le Bureau d'Admission

Partie I

Soeur Jeanne-Mance,
R.H., I.L., M.A., M.T.,
Supérieure,
Hospitalières religieuses de St. Joseph,
Montréal, P.Q.

ON A justement comparé l'hôpital à un organisme vivant, dont les fonctions ont pour but de distribuer la vitalité dans toutes les classes de la société. Source de ces activités hospitalières, le bureau d'admission représente parfaitement le coeur de cette institution. Il fournit de par son rôle essentiel qui est d'admettre le malade à l'hôpital, un principe éminent à l'oeuvre de charité qu'exerce l'établissement hospitalier. La grandeur de sa mission sociale est donc de toute première importance. De cette importance découle nécessairement l'obligation d'une organisation parfaite.

Cette nécessité d'organisation adéquate se confirme de plus en plus par la tendance actuelle que l'on a de recourir, pour la moindre indisposition tout autant que pour l'extrême urgence, à un centre médical. Nos hôpitaux regorgent de patients; au bureau d'admission donc, de résoudre le problème souvent épineux de trouver place pour ceux qui réclament leur hospitalisation.

Trouver un lit ou une chambre, ou comme le dit si bien le grand malade: "un coin quelconque", dont l'état aigu réclame l'impérieuse nécessité, voilà bien l'embarras quotidien de l'hôpital actuel. A ces heures difficiles où la liste d'attente s'allonge de jour en jour; où appels téléphoniques se font de plus en plus pressants; où médecins et malades requièrent une place, quelle angoisse de ne pouvoir répondre sur le champ. Et plus que cela lorsque des gens haut placés sollicitent l'entrée d'un malade, quel doigté sûr et prudent ne doit-on pas apporter pour ne pas sombrer dans le favoritisme! L'ordre, ce principe si nécessaire en tout revêt à l'admission une importance capitale. Il est donc évident que les malades urgents seront les premiers reçus et on s'en tiendra ensuite à la chronologie des demandes.

Des paroles aimables adressées au malade ou aux parents du malade dès son arrivée, découle souvent la réputation de l'hôpital. C'est dans ce bureau hospitalier, non exempt de tout souci matériel mais d'aspect accueillant, qu'une hospitalière au visage épanoui annoncera, publiera, pour ainsi dire par son attitude bienveillante, l'efficacité et la sympathie de sa maison. Nul ne peut nier l'importance, à ce poste éminent, d'un personnel judicieusement sélectionné.

Si le bureau d'admission a sa psychologie quant à son organisation, il a aussi sa psychologie quant à sa situation et à son agencement. De fait, il devra être d'accès facile et situé à proximité de l'entrée principale. L'endroit sera spacieux et attrayant, proportionné au nombre approximatif de malades qui se présentent. L'expérience démontre que dans bien des institutions hospitalières, l'espace accordé à ce service est par trop restreint. Le local assez vaste sera très bien éclairé. Il semble qu'il doive être muni de deux grandes fenêtres; outre la lumière plus abondante reçue de l'extérieur, on jouira de la belle nature. Loin du va et vient des visiteurs et du personnel, le bureau d'admission offrira la délicate hospitalité qui, d'emblée, apaisera l'angoisse d'étaler sa douleur devant un public indifférent. Gaie, quasi coquette, avec ses murs aux teintes sobres et variées, son ameublement choisi, son équipement complet, téléphones, accessoires récents, son éclairage moderne, cette pièce présentera le confort, invitera le malade et ceux qui l'accompagnent à y faire, sinon un arrêt de repos, du moins halte de sécurité. Le moins de cadres possible et un pot de fleurs naturelles répondent le mieux, nous semble-t-il, aux besoins psychiques du malade. Conquis par ce premier contact avec le "sanctuaire de la douleur", le patient y trouvera un appréciable adoucissement à ses souffrances.

Soeur Jeanne-Mance

Deux autres bureaux, des salles d'attente, doivent être consacrés à l'enregistrement des malades. Ces pièces devront aussi présenter un ameublement moderne, confortable et susceptible de répondre à toute autre fin inhérente à l'admission.

Dans un autre local presque attenant au bureau des comptes, un endroit plus retiré pourra être destiné à recevoir les dossiers des malades à leur départ de l'hôpital. Il est d'usage d'assurer que les patients, le jour de leur départ, quitteront l'institution avant trois heures; sinon, il vaudrait mieux ne pas annoncer leur congé car, immédiatement après l'avis certain d'un départ, le numéro de lit ou de la chambre est ajouté à la liste des admissions et la personne préposée à cette fonction peut en disposer. La liste des départs est inscrite en triplicata pour être remise au bureau de renseignements, aux archives et au bureau des comptes.

Les hôpitaux comptent actuellement parmi leur personnel, un nombre considérable d'employés laïques: hommes et femmes. Etant donné la variété des services spécialisés que comprend un hôpital moderne, il s'ensuit que le personnel religieux ne peut assumer toutes ces diverses fonctions. Voilà pourquoi il devient important de confier à une personne qualifiée la charge du personnel de l'hôpital. S'il existe un règlement et certaines formules à remplir avant d'investir un salarié de telle ou telle fonction, à plus forte raison devons-nous faire un choix judicieux des personnes chargées de l'admission à l'hôpital. Ce choix doit être basé sur des qualités naturelles ou acquises: caractère ouvert, culture générale, flair psychologique, jugement pondéré, dis-

Ce conference était donnée à Montréal et à Québec en 1950-51, lors des Cours d'administration Hospitalière, Comité des Hôpitaux du Québec. A ce temps, Soeur Jeanne-Mance était Administratice, Hôtel-Dieu de Montréal.

crétion absolue, langage soigné, extérieur sympathique et accueillant et enfin un beau sourire. Sourire qui inspire la confiance et épanouit l'entourage. Sourire qui dissipe l'inquiétude et fait oublier les malaises physiques. Sourire fait de paix et de joie bienfaisante, puissant tonique pour l'âme et pour le corps. Ce sourire, dis-je, nous devons le cultiver, l'entretenir et ne jamais le refuser au prochain. Que de bienfaits il procure et de transformations il occasionne! Le malade oublie rarement la personne qui l'accueille avec bienveillance. L'anxiété de l'âme aussi bien que la faiblesse du corps réclament des attentions charitables et délicates. Toujours très impressionnable, le patient pardonne difficilement c e r t a i n e s imperfections qui échappent à la personne désignée à l'admission, soit à son entrée, soit à son départ. Etant donné les conséquences fâcheuses ou agréables de ce premier échange de paroles, lors de l'admission, il est donc très important de surveiller la cordialité et le décorum des personnes chargées de cet emploi. Nous ne pourrons jamais trop insister sur ce premier contact avec le malade. Tout doit être surveillé, et les gestes et les paroles. Nous l'avons déjà mentionné, cette première entrevue a une répercussion qui demeure non seulement jusqu'au départ, mais bien au-delà du séjour à l'hôpital. Donnons donc au malade ce qu'il y a de meilleur en nous: notre charité et notre sympathie.

A toutes ces qualités nécessairement désirables, si nous ajoutons le titre d'infirmière voilà bien, il me semble, le meilleur agencement d'aptitudes que peut réaliser la personne destinée à cette fonction.

Enregistrement Proprement Dit

Le malade ambulant, capable de répondre aux interrogations, sera confortablement installé jusqu'à ce que l'investigation terminée, il soit ensuite prié de se rendre à sa chambre; on le fera conduire par un portier, et on utilisera une chaise roulante si l'état du malade le requiert. Les formules que vous connaissez bien qui indiquent le nom, l'âge, l'occupation, les noms des père et mère, l'adresse actuelle et l'adresse à notifier en cas d'urgence, doivent être remplies avec une très grande exactitude. Combien deviendrait embarrassante la situation de l'administratrice si, à l'occasion d'un accident, d'un décès, d'une poursuite à l'hôpital, elle ne trouvait sur la carte d'enregistrement les indications nécessaires pour résoudre ces problèmes.

On doit toujours demander au malade s'il a été hospitalisé antérieurement. Lorsque l'hospitalisation ne dépasse pas dix ans, la carte en est conservée dans les filières et il est à propos d'utiliser la même en y ajoutant, évidemment, les corrections voulues. Par ce document antérieur, on se rend compte aisément du genre d'hospitalisation reçue: chambre ou lit de salle, tarif, et parfois même indice d'un compte en collection.

Notons cependant que tout grand malade doit être admis d'urgence et sans enquête préalable. Toutefois, il reste d'usage de ne pas hospitaliser un malade ayant un compte en collection non à raison du compte, mais surtout parce que le patient refuse de s'entendre avec les collecteurs. Dans l'occurence, le patient doit recevoir en toute justice l'explication complète de cette formalité nécessaire. Tous ceux qui ont travaillé à l'administration des hôpitaux savent que les mauvais comptes sont toujours de grand problèmes. Il ne faut cependant pas que le patient ait l'impression que le genre de soins qu'il doit recevoir sera proportionné à l'argent qu'il peut donner. Tous les efforts doivent être tentés pour expliquer le coût apparemment élevé des services d'hôpital et les raisons de certaines règlementations nécessaires.

Bien qu'une très grande charité soit recommandée à l'admission, il est tout de même absolument nécessaire qu'une administratrice soit attentive et aux soins du malade et à la bonne administration financière. C'est au moment de l'admission qu'il faut demander d'acquitter à l'avance les honoraires d'une semaine d'hospitalisation. Utilisons autant que possible à cette fin le personnel laïque. Le reçu de l'argent emboursé doit être fait en duplicata: une copie est remise au malade et l'autre au bureau des comptes avec le montant perçu. C'est pourquoi nous avons mentionné au début l'opportunité de bureaux situés un peu à l'écart pour laisser au patient tout latitude de communiquer discrètement son état financier.

Dans la formation du personnel destiné à cet emploi, il est essentiel de rappeler que c'est dans cette première entrevue qu'il importe de manifester toute sa sympathie, sa cordialité et une habile compréhension à deviner ce que le patient hésite à exprimer tout haut.

Au malade dont l'hospitalisation relève du bien-être social, il est d'usage, s'il est majeur, de lui faire signer la carte de ministère ou de la municipalité. On ne doit pas insister davantage car l'assistance publique a un caractère humiliant qui répugne et offense la personalité. C'est n'est pas ici le moment de faire l'enquête que nécessitent les formules à remplir; la personne destinée à cette fonction le fera en temps et lieu, avec tact et discrétion. Aux malades qui désirent une hospitalisation de salle ou de chambre, il faut de toute nécessité laisser connaître les tarifs adoptés. D'ailleurs ces tarifs ont été discutés par nombre d'administrateurs d'hôpitaux, et il semble qu'il y ait uniformité dans la distribution suivante:

Septembre 1948 à octobre 1951
$5. pour un lit de salle
$5.50—$6.—$6.50—$7. pour chambres semi-privées
$7. — $7.50 — $9. — $10. — $11. — $14 pour chambres seules
$19.—$20. pour chambres et salons privées.

On ne doit s'efforcer de donner au malade la chambre ou le lit désiré. Il ne faut pas suggérer un montant plus élevé ou moindre que celui qu'il veut assumer. Bien des malades pour obtenir leur entrée à l'hôpital, acceptent un lit dans une salle ou une chambre et après une journée demandent un transfert, ce qui complique singulièrement le travail de l'infirmière et celui du comptable.

A l'hospitalière du bureau d'admission incombe également la fonction de connaître l'état du patient. Il est plutôt rare que des malades, en crise aigue, se présentent au bureau d'admission; ces derniers sont ordinairement enregistrés par téléphone, soit par un membre de la famille, et le transport est effectué par ambulance. D'autre part, certains malades sont amenés d'urgence à la clinique, lors d'un accident, ou transportés par ambulance spéciale des campagnes environnantes, et conduits immédiatement à la clinique ou à leur lit. Dans ces cas, une personne du bureau d'admission est chargée de se rendre soit à la clinique, soit sur les étages pour faire l'enregistrement. Il est très important d'obtenir alors la signature du malade ou celle d'un membre responsable sur la carte d'admission. La formule d'usage: "J'accepte toute opération et tous traitements qui seront jugés nécessaires par les médecins, chirurgiens et spé-

(Continué sur la page 76)

The 10th Annual Meeting of the

Maritime Hospital Association

ONCE again in the pleasant and beautiful surroundings of the Algonquin Hotel, St. Andrews by-the-sea, N.B., the 10th annual meeting of the Maritime Hospital Association was held June 6th to 9th.

The innovation of carrying the meeting over the weekend gave the delegates an opportunity for relaxation which was appreciated. Many availed themselves of the chance to motor to St. Stephen on Sunday afternoon where they were guests of the Charlotte County Hospital Board. Miss Hilda Bartsch, Superintendent, and the ladies of the hospital aid acted as hostesses.

On Saturday evening the delegates were treated to an enjoyable program by the Exhibitors Association. This annual event is one of the highlights of the convention, entertainmentwise.

Reports of the year's activities were received from President Neil D. MacLean of Charlottetown, P.E.I., and Secretary-Treasurer, Gladys M. Porter of Kentville, N.S., Dr. Malcolm T. MacEachern, Director of Professional Relations for the American Hospital Association, addressed the delegates on the fundamental principles required in operating a hospital, which he cited as organization, co-ordination, co-operation, efficiency, service, and economy.

Sectional meetings for the discussion of provincial problems were held with Ralph H. Gale presiding over the New Brunswick section, Colonel L. F. Macdonald over the P.E.I. section, and Dr. O. C. MacIntosh over the Nova Scotia section.

Explosion hazards in hospital operating rooms received a good deal of attention, the principle speaker on the subject being H. Gordon Hughes, chief of the hospital design division, Department of National Health and Welfare, with a number of prominent engineers, architects, and doctors contributing to the discussion.

Mr. Donald Henshaw, an executive of the MacLaren Advertising Company of Toronto, emphasized the importance of public and human relations. Mr. Henshaw was also the guest speaker at the annual convention dinner. His dinner address (Mr. Henshaw's second to the Association in 4 years), followed the same theme —human relations—and was truly an inspiring masterpiece. The delegates expressed their appreciation by a standing ovation of several minutes duration. An afternoon of the meeting was devoted to the discussion of Blue Cross and related hospital problems.

Nursing

Miss Gladys Sharpe of Toronto stated that a shortage of 8,200 graduate nurses existed in Canada in introducing her subject "nursing education—whose responsibility." She described the new nurse training

Some of the members of the executive of the Maritime Hospital Association are pictured above. Back row, left to right: E. J. Holland, R. H. Stocker, Col L. F. Macdonald, and A. J. Likely. Front row, left to right: Mrs. Gladys M. Porter, Neil D. MacLean, and Dr. O. C. MacIntosh.

program now operating at Toronto Western Hospital and suggested that there is need to go back 90 years and reaffirm 3 principles laid down by Florence Nightingale. Miss Sharpe cited these as follows:

1. The control of education in the School of Nursing should be in the hands of a group who are not responsible for nursing service.

2. Adequate funds must be available to carry out the task.

3. A sufficient staff of nurses must be available to provide adequate care of patients.

Miss Muriel Hunter of Fredericton, N.B., introduced Miss Sharpe and presided over the session on Nursing. Dr. S. B. Peat of Saint John, N.B., presided over a session devoted to the discussion of the utilization and training of nurses' aides during which a paper prepared by Sister Catherine Gerard of Halifax was read by Sister Jean Eudes, B.Sc., North Sydney, N.S.

Dr. O. C. MacIntosh of Antigonish, N.S., presided over round table question and answer periods dealing with a variety of hospital problems. Murrary Ross, Associate Secretary of the Canadian Hospital Council, reported on the publication of the Canadian Hospital Accounting Manual and the operation of the Council's Extension Course in Hospital Organization and Management.

Neil D. MacLean was re-elected as president of the Association for a second term. The provincial vice-presidents elected were: Dr. E. A. Petrie, New Brunswick; Dr. O. C. MacIntosh, Nova Scotia; Col. L. F. MacDonald, P.E.I.; and R. H. Stocker, Newfoundland. Other members of the executive are Mrs. Gladys M. Porter, Secretary-Treasurer; Rev. Mother Ste. Thérèse, Rev. Father M. J. McKinnon, Andrew J. Likely, Alex P. McGovern, representing the Maritime Hospital Exhibitors Association, Mrs. B. L. Moran, representing the Maritime Hospital Aids Association, and a representative of the nursing profession will be named.

Appointed to the Board of Directors of the Maritime Hospital Service Association were E. O. Hodge, P. L. Blanchet, A. J. Likely, and Rev. Sister Catherine Gerard.

Resolutions

At the concluding business session the delegates approved a series of resolutions. They went on record as expressing a sense of profound loss in the death of King George VI and affirmed their loyalty and devotion to her most gracious majesty, Queen Elizabeth II.

The Association requested the federal government to compile data and make recommendations relevant to safety precautions necessary to prevent fire and explosion of anaesthetic and compressed gasses, in use and storage. It was further resolved that the executive of the association be authorized to take the necessary steps to bring about the enforcement, by the provincial departments of health and welfare, of such recommendations for prevention of fires and explosions.

The Association commended the action of the federal government in continuing its national health program, particularly in the policy of grants for hospital construction, auxiliary services, nurses' residences, and professional training of qualified personnel. It was also urged that nominees recommended and accepted for post-graduate training bursaries be obliged to return for a specified time, upon completion of their courses, to the hospital which recommended them. It was further resolved that provincial departments of health and welfare be urged to keep hospitals fully informed of bursary qualifications well in advance of the selection date.

It was recommended that the incoming executive of the Association appoint a committee to study personnel policies and prepare data on questions, such as a minimum salary schedule, for the information of association members.

It was resolved that the Association request the federal government to reimburse hospitals for services rendered on a basis of cost or, alternately, to insure certain sections of the population (*e.g.*, Indians, Eskimos, sick mariners, et cetera) in pre-paid hospital care plans.

In the matter of steel, building materials, hospital supplies and equipment, the federal government was requested to assist in making such supplies available and to give consideration to granting priorities consistent with the defence needs of the country to assure continuous flow of needed materials.

It was requested that the Canadian Hospital Council be asked to cooperate with the Canadian Medical Association, and the Royal College of Physicians and Surgeons of Canada in developing a program of hospital accreditation.

The Association expressed its appreciation to all agencies contributing to the successful completion of the *Canadian Hospital Accounting Manual* and commended it to member hospitals.

Various resolutions of thanks were passed. They included thanks to the management and staff of the Algonquin Hotel, to the executives of the American Hospital Association and Canadian Hospital Council, to the press and radio, to the board and management of the Charlotte County Hospital and its superintendent, Miss Bartsch, to the exhibitors association,

(Concluded on page 92)

E. J. Holland, (left), retiring president of the Maritime Hospital Exhibitors Association chats with the newly-elected president, Alex P. McGovern, Halifax.

In Hospital Construction—

Snags to Avoid, Hints to Remember

Jack L. Bateman, F.H.A.,
Administrator,
Stratford General Hospital,
Stratford, Ont.

HOW can we avoid snags in hospital construction? An excellent way is to have the plans for any hospital, no matter how small, prepared by a firm of architects experienced in planning hospitals, for there are few structures more complicated to erect or equip. Of course, this is not always possible nor can one always find a clerk of works, who knows his job, to supervise the building of the larger hospitals.

Therefore, before any new construction is undertaken, it is most important for the administrative staff to develop a master plan for their hospital. Anticipate the growth of your community in the next 10 or 20 years and, if you plan to build heavenwards, see that your foundations are strong enough to carry those extra floors. If you prefer to spread your wings outwards, see that your stair wells will fit into such an expansion scheme. In any case, it is absolutely necessary to ensure that the service departments, *i.e.*, operating and delivery rooms, laboratory, x-ray, pharmacy, dietary, medical records, and general office, have sufficient floor space and enough electrical outlets to deal with the increasing loads over the years. Otherwise the hospital is no better off than before new construction, with bits and pieces of departments all over the place, making it impossible for the individual departments and the hospital as a whole to be administered efficiently. A wag once remarked that all corners in hospitals should be rounded so that staff who were so inclined could not go off and hide. That problem is covered to a great degree when departments are centered in one area. Moreover, any provison of extra space to take care of expansion adds very little to the overall cost of construction.

It is almost as important, though a little more difficult to accomplish, to see that no one department head is completely responsible for the planning of his department; because you may run into trouble and expense if he should leave before the building is completed and you are forced to start from scratch with his successor.

Dietary Department

It is an excellent idea to provide the dietitian's office with a glass partition commanding a view of as much of the department as possible. To localize noise, the dishwashing unit should be in a separate room. Where lack of space precludes this, the unit should have a dwarf wall about 5 feet high, and the ceiling should be treated with sound-absorbing material. The dishwashing machine will require a booster to bring the rinsing and sterilizing temperatures into the 180 to 200 degree F. range, as maintaining domestic hot water at either of these temperatures is dangerous to patients and staff and reduces the life of plumbing lines.

Ward kichens should be located directly over the main kitchen. Where the size of the hospital warrants two or more passenger elevators should be provided, one with a second set of doors to open directly into the dietary department for use during meal hours. There should also be a dumb-waiter to carry nourishments and special diets. It is a wise idea to have it equipped for operation by batteries, in case of an electrical breakdown.

Though not a problem in construction, may I suggest that the use of individual insulated food containers for special diets be considered. The greatest percentage of complaints about cold food come from people on special diets — simply because they are not served from the bulk food truck and their trays are often forgotten. Use of such a system for all patients is expensive but in a modified form it can prove very valuable. The provision of hot toast is always a problem. If you contemplate having 4-slice toasters in the ward kitchens, remember that these give quicker service on a 220-volt line.

In the matter of walk-in refrigerators, do not forget the value of storage space for perishables, when in season, or during buyer's market. A ceiling track, from delivery point to refrigator, for carcass meat is also something to consider.

If separate dining rooms are planned for the nursing staff and other employeees, do not have separate cafeterias since they will entail duplication of staff to provide service. The question of a pay cafeteria should also be given considerable thought.

Here are two helpful hints in regard to the dietary department. Vents should be provided to take escaping steam from urns in cafeterias, otherwise paint will peel from the ceiling; and attachments for mixers are more easily handled if a dolley is available.

Operating and Delivery Rooms

If at all possible, there should be only one entrance to operating and delivery room suites. It is common sense to have them on the same floor as the surgical and maternity units. Steam heating for these areas enable temperature to be raised quickly in the morning.

Present operating room regulations call for explosion-proof fixtures for electrical equipment. These are expensive and, therefore, should be kept to a minimum. Three wall-plugs would be sufficient in each operating and delivery room. Remember that operating room regulations do not require explosion-proof switches if these are five feet or more above floor level.

Another important point in regard to operating and delivery rooms is this: wall suction by vacuum is a necessity.

Today, with so much new equipment on the market, it is sometimes difficult to know where to draw the line when it comes to purchasing. A dual re-set

---

An address presented at a regional conference of the Ontario Hospital Association, held in London, Ont., May 7, 1952.

clock is one piece of equipment which is not necessary. It is a form of stop watch designed chiefly to enable the anaesthetist to time his gas dosage, and patient's respiration and pulse. As it is a wall fixture, the anaesthetist has to leave his stool to re-set and usually is quite happy to rely on his own watch. Certainly, the small hospital does not need them and they are quite expensive. Somehow, eight crept into our specifications but, fortunately, the makers agreed to take them back — a saving for us of more than $800.

In these times of pressure and water sterilizers, we still find it a boon to have a small instrument sterilizer in the sub-sterilizing room between the major and minor operating rooms. Besides enabling a small number of instruments to be easily sterilized between operations, *i.e.*, tonsillectomies, the steam acts as a humidifier, thus helping to counteract faulty humidifying equipment, an important factor in obtaining effective grounding for static.

The patient's signalling system from the labour rooms should be wired to the main indicator at the nurses' station. If it is wired to a sub-station located in the delivery suite, a nurse has to be there all the time or an urgent call may not be answered. As you know, nature pays homage to no one.

Control Sterilizing and Supply

No matter how small your autoclave, do make certain that it is rectangular, since there is no space wasted with this type. A loading car and transfer carriage are necessitities. There is only a difference of a few hundred dollars between the small- and large-sized autoclaves. There is one on the market which is completely automatic. All one has to do is load it, set the dials, and wait until the buzzer blows. It continues to blow until turned off. The autoclave can be emptied immediately and the next batch inserted. Here again in the matter of autoclaves it is important to anticipate future needs. If you think that you will need a second one at some future date, leave plenty of room behind for the fittings and have the wall roughed in to take it.

This may not appeal to everyone as a good idea, but at our hospital we have no water sterilizers. Distilled, sterile water is issued from central supply. The cost is negligible and the saving in capital equipment and maintenance is considerable.

Pharmacy

In planning this department, a hospital pharmacist should be consulted or the Canadian Society of Hospital Pharmacists. This society has done a great deal of work on planning hospital pharmacies.

In connection with this department, a couple of points come readily to mind. First, the pharmacist should have an office within the department, a place where he can discuss confidential matters with the medical staff and where he can receive representatives from various drug houses. Secondly, if shelves are fixed in this department, make certain that there is plenty of clearance for large bottles, about 11 inches.

Service Departments

It is an open secret that the Dominion and Provincial Governments make a capital grant for two beds where private rooms are made the same size as semi-private rooms. Fixtures for two beds should be provided in several private rooms to give added flexibility.

It is a good idea to use lacquered wall paper on the wall facing the patient, in private and semi-private rooms. Besides relieving the usual monotone, it does not show finger marks so readily and can be easily cleaned.

In regard to the size of the patient's room, do make sure that there is sufficient space for a treatment carriage besides furniture and that the doors are wide and high enough to permit the entry of a portable x-ray and a bed set up with a fracture frame.

A controversial matter is the use of individual bed pan sprays in rooms which have toilets. Personally, I think that they are dirty. Their installation should include a vacuum-breaker so that hard water from the cold system cannot back into the softened domestic hot water. At one time in our hospital, we found that the soft water in the dishwater registered 11 grains of hardness. The trouble was tracked down to several valves which were left open on bed pan sprays.

In every hospital, a choice is made between an intercommunication system from patient to the nurses' station or the signal light system. If the latter is installed, covers over call lights in the corridors should be some colour other than beige or cream. Otherwise, when shafts of sunlight stream into the corridor, the nurses will have difficulty in seeing whether the light is on or is not. Nurses' sub-stations should have natural lighting and ventilation.

In utility rooms, the use of wall brackets for instrument and utensil sterilizers makes it much easier to keep the floor clean.

Laundry. If you are building a new laundry, it does not cost too much to include a small weigh bridge. This will give you accurate figures for costing purposes. If the laundry has a high ceiling with sky lights, a canopy is not necessary over the drier. A good ceiling exhaust fan will take the heat away just as well; in fact, it will help to ventilate the whole building. If the laundry chute empties into a basement area, adjacent walls as well as the corners should be steel plated. Otherwise, you will soon need the plasterer.

Administration. The superintendent's office should be as near the main entrance as possible. In the business manager's office, it is a good idea to have a glass partition which commands a view of the general office. There must be a telephone key at the night supervisor's station so that the night line can be switched over when the switchboard closes.

General Hints

There is a special type of window screen available which has copper strips about 1/16" wide, placed at such an angle so that the sun's rays are excluded. The cost is about equal to that of the ordinary screen plus a venetian blind. When we considered that both ordinary screens and venetian blinds would be required for certain areas (even with drapes) and that the blinds would require maintenance, we decided to use the special screens for patient's rooms and for those departments facing the sun and in continuous use during the working day. The principle is excellent, though we seem to have a jinx on our screens generally. These screens can be fixed on the inside of rooms as they are in two sections which can be raised or lowered for window cleaning. Altogether, it would seem that they are much to be preferred as they will avoid the ravages of the weather and can be left up indefinitely.

This brings us to the type of window to be used. In large cities, there is no doubt that the sash which pivots on a centre hinge, even though more expensive, has much to commend it as all cleaning can be done from the

(Concluded on page 82)

Montreal Hospital Council Conducts

Successful Accounting Institute

SOME sixty administrators and accountants participated in an institute on Hospital Accounting and Statistics conducted in the English language by the Montreal Hospital Council at McGill University, Montreal, on June 4th, 5th, and 6th.

The institute program and other arrangements were in charge of a committee under the chairmanship of A. H. Westbury of the Montreal General Hospital, and included Gerard Brais of Hôpital Notre Dame, Maurice Duhamel of Hôpital St. Luc, and Charles D. Love of the Royal Victoria Hospital.

Following registration, Joseph H. Roy, president of the Montreal Hospital Council, opened the institute and welcomed the registrants who came from metropolitan Montreal, other parts of the Province of Quebec, and adjacent points in Ontario and New Brunswick.

The official textbook for the institute was the *Canadian Hospital Accounting Manual*, Chapters 1 to 4. Lucien Hébert of the Hôtel Dieu de Sherbrooke reviewed the classification of accounts and the organization of the general ledger as recommended in the first chapter of the manual.

Under the leadership of Bernard R. Blishen of the Dominion Bureau of Statistics, the revised statistical reporting schedules for hospitals, recommended by the Dominion-Provincial Conference and subsequently approved by the provinces, were reviewed in detail. Frequent comparisons were made between the definitions and instructions for completing the reporting schedules issued by the Bureau and the principles and procedures recommended in CHAM. It was evident that a number of interpretations were being placed on certain definitions and most of the difficulties arising from these varying interpretations were resolved by discussion. A number of suggestions for clarification of definitions also were made.

A. H. Westbury, Chairman of the Institute.

Walter W. B. Dick of Moncton, New Brunswick, chairman of the Canadian Hospital Council's Committee on Accounting and Statistics, ably assisted by his associate Richard B. Rice, discussed fund accounting, explaining in some detail its meaning and advantages when applied to hospital records. In the course of a discussion on the relationship between the revenue and plant funds, Mr. Dick and Mr. Rice reviewed procedures involved in calculating and recording depreciation, as well as many other hospital accounting problems.

The discussion on the recording of basic hospital statistics, as outlined in Chapter 4 of CHAM, the procedures elaborated in Part II, and their relationship to the completion of financial and statistical reports for administrative and reporting purposes, was led by Murray Ross, Associate Secretary of the Canadian Hospital Council.

Senior officers of the Montreal Hospital Council presided over the various sessions of the institute, including J. H. Roy, president; Dr. J. Gilbert Turner, vice-president; Samuel S. Cohen, secretary; Dr. Edmond Dubé, treasurer; and H. D. Jack. Rene Laporte, second vice-president, was unable to attend due to illness, and his place on the program was filled by Dr. A. Lorne C. Gilday, former secretary of the Montreal Hospital Council for many years, and treasurer of the Canadian Hospital Council.

Both evenings during the three-day institute were utilized as discussion seminars, under the chairmanship of A. H. Westbury, on hospital accounting, statistical, and administrative problems generally. The enthusiasm with which these periods were received was indicated by the fact that the registrants continued discussion beyond the scheduled time and, in the case of the second session, voluntarily re-convened at an earlier hour than that called for by the program.

A somewhat different program pattern from the customary formal lectures was followed for the most part. Addresses were brief and largely informal, freely interspersed with questions and open discussion on the principles and procedures outlined in the *Canadian Hospital Accounting Manual* and related hospital problems, with the leader taking the role of interlocutor as frequently as that of lecturer.

J. H. Roy, president, Montreal Hospital Council.

Registrants from hospitals not associated with the Montreal Hospital Council expressed their appreciation of the Council's generosity in making the course available to all hospitals. Anticipation of similar future programs was evident on all sides.

Registrants attending all sessions received certificates of attendance from Mr. Roy following the conclusion of the institute.—*M.W.R.*

83rd Annual Meeting of the Canadian Medical Association

Highlights of Interest to Hospitals

THE 83rd annual meeting of the Canadian Medical Association, brought many members and their wives to Banff, Alberta, for the week of June 9-13. As the headquarters for the meeting, the Banff Springs Hotel, could not cope with the large registration, it was necessary to provide additional accommodation at Chateau Lake Louise, situated some 30 miles deeper in scenic Banff National Park.

Commission on Nursing

Several matters of vital importance to Canadian hospitals were discussed at the general council meetings which preceded the scientific meetings. The formation of the Canadian Commission on Nursing and its accomplishments were reviewed and endorsed by the C.M.A. Now that the three parent bodies, the Canadian Nurses' Association, Canadian Medical Association, and the Canadian Hospital Council, have endorsed the commission it becomes possible to initiate steps for the development of a full-time secretariat to carry forward plans which have already been set down.

Standardization of Hospitals

Of even greater importance and significance was the acceptance by the general council of the report prepared by the special committee on Standardization and Approval of Hospitals in Canada, presented by the committee's chairman Dr. E. K. Lyon, Leamington, Ont. Four major resolutions, passed at a conference in January of the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, and the Canadian Hospital Council, were endorsed. With minor modifications these same resolutions were passed at the C.H.C. Board of Directors meeting, in Montreal on May 2nd, and 3rd.

In summary, these resolutions now establish a Canadian Committee on Hospital Accreditation, to include five representatives from the C.M.A., five from the C.H.C., and two from the Royal College of Physicians and Surgeons of Canada. The committee will establish and implement standards and programs for hospital accreditation in Canada. During the exploratory stages, the project will be financed by constituent members. A second conference of the new committee will be held early this summer to look into methods of financing so that a Canadian agency can be organized to set up standards and implement an inspection program for Canadian hospitals.

Trans-Canada Medical Services

Dr. Roy W. Richardson of Winnipeg, chairman of the committee on economics, reported on a year of progress for Trans-Canada Medical Services, the Association's nation-wide, voluntary, non-profit medical care plan (see *The Canadian Hospital*, July, 1951, page 60). Problems of integration and co-ordination of the various prepaid medical service plans, offered in different provinces, have been examined and some headway has been made in working out the many administrative details. A permanent executive director has not been appointed as yet; thus a temporary director will continue on a part-time basis. The general council voted a considerable sum of money to assist with the further development and expansion of T.C.M.S.

Report on Drugs

During the meeting a resolution was passed that the federal government be asked to limit the sale of penicillin, in all forms, by prescription only. Action by the federal government to amend present regulations governing the sale of penicillin, which would make it mandatory for a buyer to produce a prescription, is under consideration. Included in this report was the statement that the government should use all methods in its power to prevent or limit the advertising of sedative, hypnotic, and inebriating drugs to the public. It was stated that barbiturate addiction was passing alcoholic and morphine addiction in seriousness.

Delegates heard many outstanding speakers during the convention. Dr. Franklin Ebaugh, well-known psychiatrist of Denver, Colorado, spoke to a general session on "Applied Psychiatry in General Medicine" and Dr. G. F. Gibberd of London, Eng., discussed "Simple Measures in the Prevention and Treatment of Asphyxia Neonatorum". Dr. Gordon Bell, principal of Shadow Brook Health Foundation, Toronto, Ont., gave a stirring address on "Alcoholism".

Senior Members Elected

At the annual general meeting on Wednesday evening, eleven well-known and highly respected physicians from the ten provinces were introduced into senior membership. They are: Dr. Thomas McPherson, Victoria, B.C.; Dr. George R. Johnson, Calgary, Alta.; Dr. A. R. Munroe, Edmonton, Alta.; Dr. S. E. Moore, Regina, Sask.; Dr. Ross B. Mitchell, Winnipeg, Man.; Dr. Harris McPhedran, Toronto, Ont.; Dr. C. A. Peters, Montreal, P.Q.; Dr. W. J. P. MacMillan, Charlottetown, P.E.I.; Dr. J. R. Corston, Halifax, N.S.; Dr. A. J. Losier, Chatham, N.B.; and Dr. Conrad T. Fitz-Gerald, Trinity East, Nfld.

Officers

Past President: Dr. H. B. Church, Alymer, P.Q.

President: Dr. Harold Orr, Edmonton, Alta.

President Elect: Dr. C. W. Burns, Winnipeg, Man.

Chairman of the General Counil and Exeutive Committee: Dr. Norman H. Gosse, Halifax, N.S.

Honorary Treasurer: Dr. E. S. Mills, Montreal.

General Secretary: Dr. T. C. Routley, Toronto.

Deputy General Seretary: Dr. A. D. Kelly, Toronto.—*L.O.B.*

"Kagey News"

A friendly, and educational staff bulletin is being published monthly by the Kingston General Hospital, Kingston, Ont., bearing the catchy title of "Kagey News". Its mimeographed pages contain an interesting variety of hospital news, including a message from the superintendent, a write-up about one of the departments, a "who's who" column, amusing tidbits, and gay drawings.

Present it...
with motion— and sound

Almost any teaching or training program can be improved by the use of 16mm. sound film. Not only is interest added but learning is more efficient with the audio-visual combination. Such films can go right to the point and, when desired, they can carry the information, findings, technics to many different audiences.

Therapy, cerebral palsy. Photograph, courtesy of The Edith Hartwell Clinic of the Strong Memorial Hospital, Le Roy, N. Y.

Complete line of Kodak Photographic Products for the Medical Profession includes: cameras and projectors—still- and motion-picture; film—full color and black-and-white (including infrared); papers; processing chemicals; microfilming equipment and microfilm.

Present it...with
the Kodascope Pageant Sound Projector

Newest—finest—member of the Kodak 16mm. projector family. Features include: Handsome, one-case unit, complete with speaker. Superb tonal quality. Big, brilliant pictures with border-to-border screen sharpness. Completely portable—easy to carry and to set up—weight less than 33 pounds. Simple, quiet, cool operation—and it is lubricated for life. Operates on either AC or DC.

For further information see your photographic dealer or write for booklet V-4.

CANADIAN KODAK CO., LIMITED
Toronto 9, Ontario

Serving medical progress through Photography and Radiography

Kodak
TRADE-MARK

Nova Scotia and Prince Edward Island—

Health Survey Reports

Nova Scotia

The report of the health survey committee of Nova Scotia, another in the series of health surveys being financed by the federal government, was tabled in the House of Commons recently by the minister of National Health and Welfare, the Hon. Paul Martin.

Provincial health authorities indicated that the report is not to be taken as a blueprint for immediate action but that it is intended only as a guide for the future. They also pointed out that the report was compiled in 1948 and 1949 and that some of the recommendations have already been acted upon.

The report urges more co-operative planning among federal, provincial, and municipal governments to meet health needs and the development of a system of government subsidies and capital grants, together with low-cost voluntary prepayment insurance plans, to meet present needs and build up medical care, dental, and hospital facilities.

The report points out that several "check-off" or co-operative plans to finance medical and hospital care operate in Nova Scotia, chiefly in the industrial areas of Pictou and Cape Breton counties. It emphasizes that a considerable proportion of the population is in a position to afford the prepayment insurance plans provided by the Blue Cross, Blue Shield, Maritime Medical Care Inc., and the co-operatives, if the public is adequately educated to appreciate their value.

In its section on medical and dental manpower, the report urges that provincial grants from the four Atlantic provinces toward the medical and dental faculties of Dalhousie University be placed on a more permanent basis and that the costs be shared fairly among the four provinces. It was also pointed out that a small number of doctors already receive a basic salary from the province for practising in isolated areas. It was recommended that these subsidies should be extended to more doctors, dentists and possibly to home nursing services, with payment depending on the doctor or dentist providing preventive, public health services.

Substantial progress in the development of mental health services was noted in the section on mental health, including the establishment of a division of neuropsychiatry, improved services at the Nova Scotia Hospital and the Nova Scotia Training School, field psychiatric services at Yarmouth and Sydney, and a psychiatric service at the Victoria General Hospital, Halifax. Expansion of field psychiatric services on a part-time basis is also recommended in other sections of the province and the establishment of a home for the lowest grade of mentally defective children.

Regarding county and municipal homes, hospitals, and asylums, the

(Continued on page 84)

* * * *

Prince Edward Island

Continuation of present voluntary prepayment plans for hospital care, supplemented by publicly operated diagnostic centres, highlights recommendations of the Prince Edward Island health survey report.

The report, prepared by the Provincial Health Planning Commission, notes that the present voluntary plan for hospital care has a number of drawbacks, chiefly that it is not "optimally organized, supervised nor distributed" and its activities are limited almost entirely to curative medicine. It was agreed by the committee that "medical service should eventually provide everything that science can offer toward the preservation of health and the cure of disease and that these benefits should be made available to the entire population." However, the report notes that the new diagnostic and curative procedures have raised the costs of medical care and complicated the distribution of medical services so that medicine of high quality has become increasingly beyond the reach of lower income groups.

Members of the commission agree that local government authorities and local professional groups should participate in the application of all government-financed medical services. They urge also that hospitals extend their scope to become health centres, providing all types of preventive and curative medical services.

The report recommends that for the present time, the Blue Cross hospital plan be continued and suggests that the provincial government meet the premiums for all persons without any income and a portion of the premium for those with low incomes and for dependents. Such a development would require rules concerning quantity and quality of services to be provided, as well as costs and methods of administration.

To provide more adequate services to prevent disease and to reduce the costs of illness, the report recommends development of diagnostic centres providing x-ray and laboratory tests and, perhaps, consultation services of medical specialists.

The commission recommends a reorganization of the provincial Department of Health and Welfare and an expansion of its services. Provincial health authorities point out that a number of these suggestions have already been carried out. Recommendations are made that the 480 boards of health be reduced to 20, each board to consist of five members, and that the 20 districts be divided into an eastern and a western area, with a qualified medical officer of health for each area. The centres of the two areas would be Charlottetown and Summerside.

Recommendations on nursing include more residence accommodation, bursaries for graduate nurses, assistance to practical nurses while being trained in Moncton, N.B., a recruitment campaign for both professional and practical nurses, and financial assistance to prospective nurses to help them complete their education, a grant to the Prince Edward Island Registered Nurses' Association, a pension program for nurses, revision of provincial legislation on nurses' registration, and establishment of a division of nursing in the provincial health department. Provincial health authorities point out that legislation implementing some of the recommendations on nursing has already been approved by the provincial legislature.

Hunt's Limited, Canadian Candy and Ice Cream Manufacturer, Bakery and Restaurant Chain

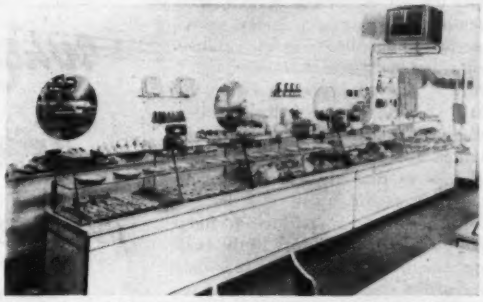
finds FRIGIDAIRE "The Better Kind" of Air Conditioning and Refrigeration

Hunt's Limited, whose slogan "The Better Kind" is a well-known "buy-word" for good candies, ice cream, baked goods and restaurant service, bought their first Frigidaire equipment thirty years ago. Their Frigidaire installations today include ice cream cabinets, delicatessen counters, soda fountain and back bar refrigeration and air conditioning.

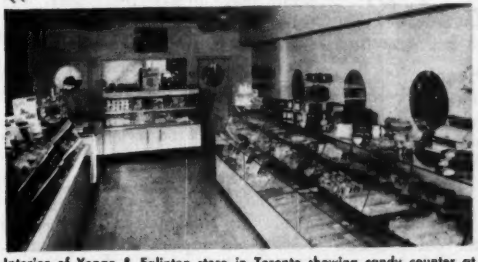
Hunt's lay greatest stress on their Frigidaire Air Conditioning. "We don't think of building a store now without air conditioning", they say. "Air conditioning keeps our cream goods from souring, our chocolates from turning grey, our hard candy from becoming sticky.

"We have had people tell us they like to shop in our stores because of the air-conditioned comfort. We know that our girls work more efficiently, with less fatigue, because of our Frigidaire Air Conditioning."

One of the thirty-six Hunt's Limited stores in Toronto — this one, air conditioned by Frigidaire, is on north Yonge Street at Eglinton Avenue. Circle Refrigeration Limited handle Frigidaire sales and service to Hunt's Limited in the Toronto area.



View showing cake counter and Frigidaire Air Conditioning installation at front of 322 Bloor Street West store in Toronto.



Interior of Yonge & Eglinton store in Toronto showing candy counter at left, baked goods counter at right and Frigidaire-refrigerated delicatessen counter and Frigidaire Ice Cream Cabinet at rear.

Frigidaire-refrigerated soda fountain and back bar at Hunt's Limited store at 322 Bloor Street West in Toronto. Air Conditioning vents visible at rear.

Why not bring to your business the advantages that Hunt's Limited have found in Frigidaire equipment? What Frigidaire will do for you can be shown by a simple Frigidaire Refrigeration Security Analysis which any Frigidaire dealer listed below will give you absolutely without obligation. It may show that your *present* equipment is entirely adequate — or needs only some small attention such as a compressor overhaul. Find out now.

Call your nearest dealer or write Frigidaire Products of Canada Limited, Scarborough, (Toronto 13), Ontario.

FRIGIDAIRE

MADE ONLY BY GENERAL MOTORS

CALL OR WRITE YOUR NEAREST FRIGIDAIRE HEADQUARTERS LISTED HERE

ST. JOHN'S, Nfld.	Baine, Johnston & Co., Ltd.
HALIFAX, N.S.	R. Simpson Eastern Ltd.
NEW GLASGOW, N.S.	J. O. MacLeod
SYDNEY, N.S.	C. P. Moore Limited
TRURO, N.S.	Hillman Electric Appliances
WOLFVILLE, N.S.	G. D. Denton, Box 160
CHARLOTTETOWN, P.E.I.	R. T. Holman Limited
SUMMERSIDE, P.E.I.	R. T. Holman Limited
FREDERICTON, N.B.	Oswald E. Merrithew
MONCTON, N.B.	Lounsbury Company Ltd.
SAINT JOHN, N.B.	Refrigeration Service Ltd.
MONTREAL, Que.	Triangle Refrigeration Co.
NORANDA, Que.	Eder Refrigeration
QUEBEC, Que.	Vandry Inc.
THREE RIVERS, Que.	Alphonse Rousseau
SHERBROOKE, Que.	Paul Leprohon H. C. Wilson & Sons
BRANTFORD, Ont.	Maich Refrigeration
CHATHAM, Ont.	Erie McDonell Sales & Service
COBOURG, Ont.	Lyle Motor Sales
HAMILTON, Ont.	Refrigeration Sales & Service
HUNTSVILLE, Ont.	Olan Bros.
KINGSTON, Ont.	W. W. Hawley Limited
KIRKLAND LAKE, Ont.	A. M. Siegrist
KITCHENER, Ont.	Halwig Motors Limited
LONDON, Ont.	Stone-Stewart Limited
NORTH BAY, Ont.	Consolidated Electric Shop
OSHAWA, Ont.	Hugh Morrison Home Appl.
OTTAWA, Ont.	Federal Appliances Ltd.
SARNIA, Ont.	Bayly's Refrigeration
SAULT STE. MARIE, Ont.	Hannah Electric
ST. CATHARINES, Ont.	A. A. Widdicombe & Son
SUDBURY, Ont.	Wm. Hamilton Electric Ltd.
TIMMINS, Ont.	Earl Hurst
TORONTO, Ont.	Circle Refrigeration Ltd.
WINDSOR, Ont.	T. W. Savill
FORT WILLIAM, Ont. WINNIPEG, Man. REGINA, Sask. SASKATOON, Sask.	The J. H. Ashdown Hardware Co., Limited
CALGARY, Alta. EDMONTON, Alta. LETHBRIDGE, Alta.	Bruce Robinson Electric Ltd.
VANCOUVER, B.C. VICTORIA, B.C.	McLennan, McFeely & Prior

Food and Its Service

Sponsored by
The Canadian Dietetic
Association

What is a Regional Nutritionist?

Dorothy Hagar
Provincial Nutritionist,
Department of Public Health,
Province of Saskatchewan,
Regina, Sask.

WHAT is a regional nutritionist and what are her duties? Perhaps the following description will give you some idea.

The scene opens at the local school house where grandmothers, mothers, fathers, young brothers and sisters, and all other interested folk in the community, are gathered. Curiosity has reached a high point in this district during the past six weeks — ever since the school children began experimenting with nutrition. Today, everyone has gathered to hear the children tell what they have learned. Timmy was fed a good breakfast during the six weeks and a line graph shows that he gained weight steadily. The story written about him by Judy in Grade VI tells us that his hair is "smooth and soft as silk" and that he has "bright, shiny eyes and loves to romp and play." Thus the story of the feeding experiment unfolds and it is only one of the active nutritive projects for which a regional nutritionist might be responsible.

This busy person has a number of activities to carry out in a working territory which is not small — a health region in Saskatchewan. One of these regions comprises an area of 93,000 square miles with a population of 62,000.

The staff of a typical health region consists of a medical health officer, public health nurses, sanitary officers, dentists, a health educator, and a nutritionist. Ten nurses who are working constantly with children and mothers have many opportunities to teach nutrition every day. In-service training, then, is an important part of every regional nutritionist's program.

It might be said that the key to a successful nutrition program is teamwork. In addition to in-service training carried out at regular staff conferences, the nutritionists work hand in hand with dentists, nurses, and other members of the health region staff.

The regional nutritionist is a resourceful person who can contribute to almost any health education program. In co-operation with dentists, dental programs are conducted in some centres. Elsewhere, restaurants are the scene of activity as a sanitary officer and nutritionist work to assist the manager in developing a better food service. Other activities bring her in contact with larger groups of people. Would you care to join me in an imaginary trip to visit with these young ladies as they carry out some of their duties?

First of all, we drop into a one-room rural school house. In making her routine inspections, the public health nurse reported that school lunches were poor in this district. What were the reasons for this? The teacher had taught her pupils what a good lunch should contain. She had tried to organize a hot lunch program but the parents were indifferent.

Tonight the home and school club is meeting. All parents have been urged to attend with the promise of a special speaker and a film. As we enter everyone is listening attentively as the nutritionist speaks.

The program proceeds and whispers can be heard around us. "I didn't know that Johnny needed that much food at noon." "Maybe Dave could do better work if he had some milk and meat or egg sandwiches — our honey is almost used up anyway."

Before the evening is over, I am sure that this school will have a lunch pail brigade of better lunches each day, with a plan for something hot on cold days.

At the next stop we hear a slight clatter of dishes as we step inside the town hall. The nutritionist is preparing one of the less tender cuts of meat. The mothers present, as in all parts of Canada today, are faced with feeding their families adequately on a limited budget. A local ladies' group heard about classes given by the regional nutritionist in other centres. They made the necessary arrangements and are sponsoring this nutrition class now taking place.

It is a very keen group. The women want to know more about cooking other cuts of meat. "Should all vegetables be cooked just that long?" The nutritionist has cooked some carrots to serve with the stuffed flank of steak. The steak and carrots, with a baked potato, make an attractive dinner. The ladies are sampling now. General comments of approval can be heard. They agree that it is a delicious dinner, easy to prepare and nutritious and economical, too!

The magic carpet swishes again and we find ourselves at a teachers' institute. Rural school teachers have gathered to discuss some of their problems. The regional nutritionist has been given a place on the program. She will discuss the various ways in which nutrition teaching might be worked into the general curriculum. Projects, such as a good lunch program, animal feeding experiments or a good breakfast campaign are only a few. The curriculum lends itself very well to incorporating nutrition teaching. The goal is to make it an all-school program with nutrition teaching planned continuously throughout all grades.

Our trip on the magic carpet has only shown us a few of the activities of a regional nutritionist. As a part of a public health team, her ultimate goal is optimal health for all. It is now generally recognized that this optimal health is not possible without the right food. As in all public health work, changing ingrained habits is a slow process. It is a task less rewarding than some other fields of dietetic work but it is a definite challenge.

NOW available in Canada!

New Formula

JOHNSON'S BABY LOTION

hospital-proved scientific protection against impetigo—cradle cap — excoriated buttocks — heat rash and diaper rash

New Formula Johnson's Baby Lotion with hexachlorophene 1% has been demonstrated to be highly effective as a preventive and therapeutic agent for the major skin afflictions of infancy.

It consists of a non-toxic, non-irritating, oil-in-water emulsion. New formula lotion produces a discontinuous film having the ability to protect the skin from external irritative agents, without interfering with its normal physiologic functions.

PROOF: New formula Johnson's Baby Lotion was subjected to clinical investigations in many large hospitals, for a period of more than 10,000 baby days. It reduced the incidence of skin irritations *of all types* to an average of less than 2%.

FREE!
Mail coupon for free samples...

Johnson & Johnson
LIMITED MONTREAL

Johnson & Johnson Limited,
2155 Pie IX Blvd.,
Montreal, Que.

Please send the following free samples of New Formula Johnson's Baby Lotion . . .

☐ 1 oz. distribution samples
☐ 3 oz. clinical trial bottle

Name.....

Street.....

City..... Prov.....

Notes on Federal Grants

Construction

An addition is being made to St. Michael's Hospital, Buckingham, Quebec, which will provide space for 128 more beds; a 24-bassinet nursery; modern medical, surgical, and obstetrical services; and a community health centre. The federal grant toward the building costs will total $145,500.

The new Siglunes Hospital at Ashern, Manitoba, has received a federal grant of $10,000 to help towards its building costs. When construction is completed later this year, the hospital will have space for seven beds, a three-bassinet nursery, surgical and obstetrical facilities, and living quarters for the nurses. It will serve a large but rather sparsely settled area in northern Manitoba.

A new hospital is being built at Hartney, Manitoba which will have space for four beds, a three-bassinet nursery, obstetrical facilities, living quarters for the nurses, and an office and clinic for the local health unit. The federal grant toward the cost of this construction will be about $8,000.

The new Sudbury Memorial Hospital, Sudbury, Ont., will receive more than $244,600 toward the cost of providing accommodation for approximately 150 patients, a 44-bassinet nursery, a small unit for the care of the chronically ill, and a 60-bed nurses' residence. The hospital will serve Sudbury, Capreol, Conniston, Copper Cliff, Chelmsford, Frood Mines, and surrounding townships. Construction will be completed in 1954.

At the Toronto East General and Orthopaedic Hospital, the nurses' residence is being enlarged to provide space for 69 additional nurses. The federal grant will be $34,500.

The Peel Memorial Hospital, Brampton, Ont., is providing space for 16 more nurses by enlarging its present nurses' residence. The federal grant toward this will be $8,000.

The Jewish Hospital of Hope, Montreal, has been granted $18,000 to help meet the costs of extending its bed accommodation for the chronically ill. St. Joseph's Hospital for Convalescents, Bordeaux, will receive a grant of $24,000 toward the cost of adding space for 48 additional beds in its residence for nurses' aides. Construction is scheduled for completion later this year. A federal grant of $25,500 will help the Hotel Dieu, Quebec City, to enlarge its nurses' residence.

Personnel

Two public health bursaries have been awarded to Winnipeg residents. A dairy inspector for the Winnipeg health department will spend a year at the University of Michigan in order to do post-graduate work in sanitary science. An inspector of milk pasteurizing plants for the Winnipeg health department will attend a refresher course at the University of Illinois and observe the latest procedures in pasteurization as practised by the Illinois State Department of Health.

Public Health

A federal grant of approximately $12,300 has been allotted to St. Michael's Hospital, Buckingham, P.Q., to buy laboratory and x-ray equipment for out-patient services. St. Mary's Hospital, Montreal, will receive a grant of $2,000 to purchase additional laboratory equipment. Funds have also been allotted to buy two additional incubators for the maternity department of St. Luke's Hospital, Montreal.

The first child guidance clinic to be set up in Ontario in conjunction with a health unit is to be established in the East York-Leaside area near Toronto, Ont., with the support of a federal health grant. The new clinic will provide facilities for diagnosis and treatment of children who have problems of behavior, personality, or habit which make it difficult for them to adjust themselves to life in school, their homes, or in the community. The clinic's staff will work with the children's parents and carry out a general program to prevent mental maladjustments by educational and consultative services to schools, health and welfare agencies, and parents' groups.

The staff will consist of a psychiatrist from the Ontario Department of Health, a full-time psychologist, a full-time social worker, a secretary-stenographer, and a part-time psychologist. The federal grant of $13,850 will assist with the salaries of the staff and provide equipment for the clinic. The health unit is providing space, utility and maintenance services. Other child guidance clinics in Ontario operate separately from health units; therefore, the East York-Leaside clinic is a pilot project to see if economies can be made in overhead costs and to determine the extent to which psychiatric services can be meshed with the general activities of the health unit.

Federal funds have also been allotted for the salary of a part-time health educator for the East York-Leaside unit. She will assist the present staff in developing health education in schools and community groups as a means of fostering better health habits and preventing illness.

Effective Preventive Measures Needed to Maintain Immunity to Smallpox

The following is an excerpt from an article by Drs. A. S. Benenson, C. H. Kempe, and R. E. Wheeler entitled "Problems in Maintaining Immunity to Smallpox" which appeared in the *American Journal of Public Health*, Volume 42, page 535, May, 1952.

"A review of the smallpox status of today can best start with the outbreak which occurred in 1950-51 in Brighton, England. In this city, in one of the most highly civilized countries on earth, 29 confirmed smallpox cases followed the return of an infected RAF officer from India. Eighteen of these patients had never been vaccinated, 7 of them died. Of the other 11 cases, 3 of whom died, only 2 had been re-vaccinated after infancy; 1, the source case, as recently as 2 years before contacting the disease. There is particular irony in the fact that 12 cases with 6 deaths occurred among the staff of the isolation hospital which admitted the early cases. Nine of these staff cases had never been vaccinated; furthermore, of the entire staff of 110 persons, one-quarter had never been vaccinated. What better illustration could be found of the current neglect of an effective preventive measure?"

No one is so busy as the man who has nothing to do.

Provincial Notes

Quebec

MONTREAL. At an official ceremony in May, a new pathology laboratory was opened at the Reddy Memorial Hospital. The laboratory will not only fill the needs of the hospital but will also form part of the cancer control centre, which is in operation there. Three houses, located adjacent to the hospital, were donated to it recently and will be converted into nurses' residences.

* * * *

SWEETSBURG. A campaign was launched recently to raise $675,000 for the new Brome - Missisquoi - Perkins Hospital. Designed by Edward J. Turcotte, Montreal, the new hospital will have a bed capacity of 57.

Ontario

BARRIE. The new $500,000, 50-bed addition to the Royal Victoria Hospital will be officially opened at the end of this month.

* * * *

HANOVER. Fire broke out recently in the attic of the Hanover Memorial Hospital. Eleven patients, including a baby, were quickly removed to safety from the 14-bed institution. Although firemen succeeded in extinguishing the blaze before it spread to the two lower floors, much water was necessary to control the fire and damage is estimated at $40,000. It is expected that some months may elapse before the building can be used. An addition had already been planned for the hospital and most of the estimated cost of $260,000 has been raised.

* * * *

KINGSTON. Construction of the Angada Children's Hospital is progressing steadily, with the outside work almost completely finished. It is expected that the 81-bed institution, which is part of the Kingston General Hospital, will be ready for occupancy this fall. Expected to cost approximately $650,000, the hospital will have facilities for orthopaedic and plastic surgery, as well as general surgery.

* * * *

SIMCOE. Contracts have been awarded for the construction of a new wing at the Norfolk General Hospital. The new wing, which will provide space for 52 beds, will almost double the hospital's present capacity. To be constructed east of the present building, the exterior walls of the wing will be of brick to harmonize with the older section. New administration offices, kitchen, dining room, and snack bar will be among the features of the addition. It is expected that the total expenditures, including the new heating plant which was erected in 1951, will be approximately $800,000.

* * * *

SMITH FALLS. The municipal council has voted in favour of allotting a $10,000 grant to the St. Francis General Hospital. The grant will help cover the cost of constructing a new 20-bed wing.

* * * *

ST. CATHARINES. The corner stone for the new Hotel Dieu Hospital was laid in May. Construction on the new 125-bed hospital is now well advanced and it is expected that the building will be in use early in 1953.

* * * *

TIMMINS. A special committee has been set up to investigate the possibility of constructing a much-needed addition to St. Mary's Hospital. The project was under consideration in 1940 and again in 1950 but lack of financial support made it impossible to carry out. Present plans call for the construction of a 100-bed wing.

* * * *

TORONTO. A request for a capital grant of $450,000 has been made to the city's board of control by the Women's College Hospital to assist in a $3,000,000 building campaign. The proposed building plans call for the addition of 145 adult beds and 96 bassinets, a new laundry, improved kitchen and dining room facilities, a nurses' residence, and other essential services. It is proposed to construct two new wings, one of which would house a new out-patients' department, an extended x-ray department, and 129 beds; the other wing would contain the new laundry, the extension to kitchen and dining room facilities, and 16 beds. The nurses' residence would house the nursing staff and training school.

* * * *

WINGHAM. Tentative plans for the addition of a new, $350,000, 50-bed chronic patients' wing to the Wingham General Hospital are under consideration by the hospital's board. A grant of $175,000 for the addition has already been approved by the provincial department of health.

Alberta

EDMONTON. The new $350,000, five-storey wing of the Misericordia Hospital was opened in June. Connected to and extending from the front of the older hospital, the new wing is 46 feet wide and 77 feet in length. It has space for 61 beds and raises the hospital's present capacity to 367. The first floor is being used for the administrative offices, while the second and fourth floors have accommodation for private ward patients, and the third and fifth floors contain semi-private wards.

* * * *

WETASKIWIN. A money by-law, which will allot funds for the construction of a nurses' home and enable certain alterations to be made in the Community Hospital, received the support of a large majority of property owners. The residence will be built

on a vacant lot adjacent to the hospital. Alterations will be made in the hospital's basement to allot space for 14 additional beds. It is expected that the residence and alterations in the hospital building will cost approximately $150,000. The city's share of the total estimated expenditures will be $50,000, which will be raised by debentures. The municipality will be asked to raise $75,000 and $25,000 will be available from federal and provincial grants.

British Columbia

SOUTH BURNABY. One of the highlights of South Burnaby's Diamond Jubilee Week celebrations, from June 30th to July 5th, was the opening of the new 150-bed Burnaby General Hospital. Kitchen and dining room facilities, as well as the laundry, linen and sewing room, lockers, pharmacy, and dietitian's office, are located in the basement of the four-storey building. Administrative offices and the emergency operating room are on the ground floor, with the second floor being used entirely for patient accommodation. Two major and one minor operating rooms are located on the third floor and the maternity section is on the fourth floor. The building has been constructed so that an additional 150 beds may be added as the need arises.

* * * *

VANCOUVER. At an official ceremony in May, the 264-bed, $1,800,000 Pearson Tuberculosis Hospital was opened. The hospital's service facilities are large enough to take care of an additional 264 beds, without being enlarged.

Where There's a Will

An experiment in simultaneous "willing" took place in a London office recently, with unforeseen results. An hour before going-home time five of the staff set themselves to "will" the man in charge to notice that things were slack and to send at least some of them home early. "Go home, go home," they said in their mind, over and over again. After five minutes the man in charge seemed to be looking unsettled. After ten minutes he got up, put on his hat and coat, and, telling his second-in-command to take over, went home.—*Manchester Guardian.*

With the Auxiliaries

Branch Auxiliary Makes Donation to Hospital at Sydney Mines, N.S.

The newly-organized branch at Florence, N.S., of the ladies auxiliary to the Harbour View Hospital, Sydney Mines, N.S., has made a substantial donation to the hospital. It will be used to purchase six rocking chairs and two sets of tables which will be placed in the nursery when the new wing, which is under construction is opened. This group recently sent two dozen sheets to the hospital. Members meet once a month and devote the first part of the meeting to business, with the remainder spent sewing articles.

* * * *

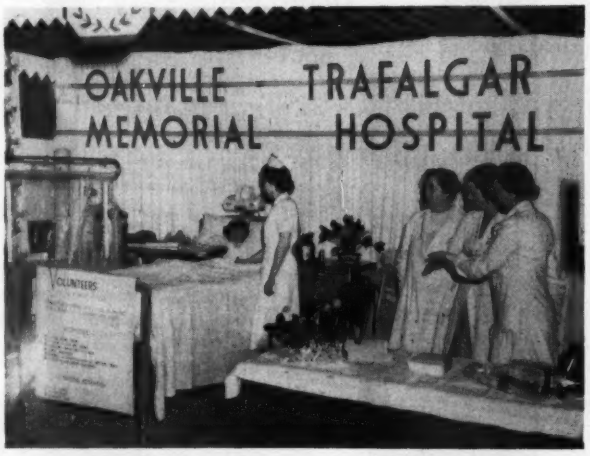
Room Furnished by Auxiliary at St. Michael's Hospital, Toronto

Major projects, undertaken by the women's auxiliary to St. Michael's Hospital, Toronto, Ont., during 1951, include furnishing a room in the new wing at an approximate cost of $1,000, and the award of a scholarship to a member of the nurses' graduating class. A total of 10,567 items were made for the hospital. Receipts for the year were $2,923 and disbursements totalled $1,964. The auxiliary has a membership of 52.

* * * *

New Auxiliary Formed to Serve Hospital at Markdale, Ont.

Women, representing nine municipalities, recently formed a hospital auxiliary to serve the Centre Grey General Hospital, Markdale, Ont. A bazaar and tea party, at which many prominent speakers took part, was held on May 10th to celebrate National Hospital Day. Although the auxiliary is newly-formed, many ambitious plans are under consideration.



Hospital Services Displayed at Home and Industry Show

Members of the women's auxiliary to the Oakville-Trafalgar Memorial Hospital, Oakville, Ont., pictured at the extreme right, exhibited their tuck wagon at a recent Home and Industry Show held there. A replica of a hospital room, complete with curtains, oxygen tent, bed, tables, a live patient, and a nurse on duty was displayed by the hospital in the same booth. The exhibit proved to be most popular and gave some 4,000 persons, who viewed the three-day show, an excellent opportunity to see some of the work carried on in the hospital. Copies of the institution's annual report, along with a rose, were given to visitors by the members of the auxiliary. Approximately $250 in donations was raised during the show.

Importance of Voluntary Effort

In speaking to the ladies auxiliary of St. Mary's Hospital, Montreal, at a meeting in May, the Hon. Paul Martin, Minister of National Health and Welfare, emphasized the importance of voluntary effort. Mr. Martin spoke of the many developments in hospital services and said: "In all of these developments, those who serve our hospitals, in a voluntary capacity through ladies' auxiliaries and other interested groups, have an important part in strengtheing and supporting the efforts of those directly responsible for the maintenance and operation of the hospital. Like any large organization, a hospital must be operated on a basis of team-work."

Mr. Martin continued: "I often think that the modern hospital, with all its streamlined efficiency, could be a very cold and impersonal institution. It is the personal element, more than anything else, that can effectively humanize a hospital. A ladies' auxiliary can do much to help improve human relations by giving doctors, nurses, and other members of the hospital staff, a sense of belonging to a big and friendly family, and by bringing extra cheer into the lives of its patients."

British Columbia and P.E.I. Join in Blindness Treatment Plan

Selected persons receiving blindness allowances in British Columbia and Prince Edward Island are now eligible to obtain surgical and remedial treatment to restore their sight, according to a recent release from the Department of National Health and Welfare, Ottawa. The treatment scheme is an outgrowth of an experiment begun in 1949; already Newfoundland, Nova Scotia, New Brunswick, Quebec, and Ontario are participating in it.

The plan has been limited to selected persons as only certain recipients of blindness allowances will respond to treatment. Each case to be treated is carefully selected after consultation with the federal health department's blindness control division, the treating oculists, and the provincial authorities. No treatment is given without the consent of the patient and it is administered by a specialist in the province where the patient resides. The federal government pays 75 per cent of the cost of treatment and the province the remainder.

SEAMLESS

PRO-CAP

ADHESIVE PLASTER

1 – *Sticks Easily and Well*
2 – *Causes Little or No Irritation*
3 – *Does Not Slip or Creep*

Because — Fatty acid salts in the mass—zinc propionate and zinc caprylate—reduce skin maceration and slimy deposit and retard the growth of bacteria and fungi. Write for results of clinical tests.

Prove it to Yourself–

Write for a FREE spool of Pro-Cap. If you are irritated easily by plaster, make a side-by-side patch test on your forearm using Seamless Pro-Cap and any other adhesive plaster. Leave tape on 48 hours —see the difference! Prove to yourself that Seamless Pro-Cap causes little or no skin irritation.

FINEST QUALITY SINCE 1877

1877 75th 1952

SEAMLESS

With the Hospitals in Britain

The Midwife in Great Britain

IN Great Britain, the midwife is a medical auxiliary of high professional standing. The history of this profession and its place in British health services is long and interesting and is described by Fraser Brockington, M.R.C.S., L.R.C.P., D.P.H., professor of social and preventive medicine at the University of Manchester, in the *Canadian Journal of Public Health*, April, 1952. The following excerpts are from his article.

. . . In the nineteenth century, much of the blame for mortality in childbirth fell upon the unsatisfactory way in which domicilary midwifery was practised, including the use by doctors of unskilled persons as handywomen. This was a continuation of the function of women in childbirth which must have persisted from the earliest days of man, (no doubt even before the discovery of fire) as it does today little altered amongst primitive peoples. Such women in general had no professional training, although we know that in the Middle Ages in England, women were licensed for the work by the Church. In the last century, when the social conscience of England began to stir in so many different spheres of our life, and with the stimulus of science to alter men's outlook, the unqualified midwife seemed, to enlightened people, to be an evil. Dickens created the character of Mrs. Gamp, who combined laying out the dead and midwifery, much as at one time the art of surgery was combined with that of the barber. When Dickens wrote, we were already behind other countries, for, in 1803, France and, later, other European countries regulated the training of midwives. The Obstetrical Society, created in England in the middle of the last century, took a first courageous step by setting up a certificate for midwives in 1872. This proved sufficiently attractive to be held by over 5,000 midwives at the end of the century. From 1872 to the first Midwives Act of 1902, a battle was waged for state certification. It is difficult at this distance of time and perhaps not very profitable to try to recapture the atmosphere of those days. There can be few in Britain today who would wish to go back to Mother Gamp and any objections now to training and certification seem hardly valid. Yet, then, the opposition was great both in Parliament and out. The doctors, or rather a section of them, felt that they could do all the midwifery and wished to see the extinction rather than the preservation of this woman. Members of Parliament saw great hardship for the enormous numbers of women who gained some sort of livelihood from an unregulated trade. Bill after bill went before Parliament, to be thrown out or to be talked out in committee stages, until at last in 1902 the first Midwives Act was passed.

This Act created the Central Midwives Board which has now operated for half a century, being today composed of 14 members, including at least four general practitioners, four midwives, and one medical officer of health. The Act stated that after 1905 no woman who was not on the register of the Board could lawfully call herself a midwife; that after 1910 no woman could habitually and for gain attend women in childbirth unless certified or under the direction of a doctor. The names of women were entered on the Midwives Roll if they held the certificate of the Obstetrical Association and if in *bona fide* practice for a year before the passing of the Act.

The "bona fide" midwife, whose numbers were at first considerable, only slowly disappeared. In 1931, I remember one such person in Worcestershire who carried a midwifery bag empty except for a rusty pair of old scissors with which to cut the cord. The duty of supervising midwives under the new Act, one of the new personal health services, was placed upon County Councils and County Borough Councils, in contrast to the strictly sanitary legislation. The task proved to be one of great difficulty, for the existence, in large numbers, of the bona fide midwife continually obstructed the creation of new standards.

However, even greater, were the difficulties arising from the interpretation of the Act itself and magistrates were unsympathetic to any rigorous enforcement of a law which could bring hardship to those dependent upon midwifery for a livelihood; and they tended to interpret the words "habitually and for gain" in favour of any offenders brought by the authorities before the petty sessional courts. The phrase, "under the direction of a doctor" was also capable of varying interpretation; and Gamps went on practising under the nominal umbrella of a doctor. Among these pitfalls, local authorities had to thread their way with care and circumspection. Little good came from prosecuting women for practising without a certificate of the Central Midwives Board when magistrates refused to convict or convicted with a nominal fine. Thus the growth of the new profession of midwifery was slow, and most medical officers of health of a generation now past realized that only the passage of time itself and the growth of a new generation of professional women would cure the evils that existed.

In 1929, a special committee examined the details of 5,800 maternal deaths and published valuable reports of their findings (1920 and 1932). In brief, they said that nearly half the deaths were preventable. These reports did much to influence the creation of a municipal midwifery service (Midwives Act, 1936), which has since resulted in a nation-wide service staffed mainly by whole-time midwives. The

These excerpts are reprinted through the courtesy of the "Canadian Journal of Public Health."

Stille Instruments

Ohio Chemical & Surgical Equipment Co. is the exclusive importer of world-famous Stille surgical instruments manufactured by A. B. Stille Werner, Stockholm, Sweden. The Stille trademark stamped on each genuine Stille instrument is a pledge of finest workmanship and materials in a century-old tradition. Genuine Stille instruments bear the two-word trademark, "Stille Sweden" — together with two stars — the third star on the trademark indicates the instrument is made of stainless steel. Ask for Catalog 2077.

Scanlan Sutures

W[illegible] sterile. Only [illegible] suture materials are used, tested for uniformity of strength, flexibility, and absorption. A variety of types with and without special needles attached. Ask for Catalog No. [illegible]

Scanlan Surgical Needles

Ideally adapted to the need — [illegible] and designed. Now available in all-[illegible] containers with replaceable cap and [illegible]-proof seal. Needles are kept conveniently visible, rustless, dustless, and damage-free.

NOW!
Ohio-Scanlan "TRI-DERMAL" STERILJAR

A new convenience for the hospital emergency room or doctor's office — the Ohio-Scanlan "TRI-DERMAL" Steriljar.

All the features of the popular, handy Steriljar PLUS the added advantage of *three* types of sutures in ONE JAR. Sutures are positively maintained in individual compartments by means of molded rubber separator, conveniently marked as to contents. Ideal for use where smaller quantities of sutures are more practical.

Send for these [illegible] catalogs

Ohio Chemical Canada
LIMITED

[illegible]

OHIO HOSPITAL EQUIPMENT — [illegible] Anesthetic Apparatus • [illegible] • Central Oxygen Piping • [illegible] Sterilizers • Ohio Scanlan Surgical Tables • [illegible] Surgical Lights • Scanlan Surgical Sutures and Surgical Needles • [illegible] Furniture • [illegible] Cabinets • U. S. Distributor of Stille Instruments

OHIO MEDICAL GASES — Oxygen • Nitrous Oxide • Cyclopropane • [illegible] • Helium and Mixtures • Also [illegible]

improvement, particularly in areas inadequately covered by voluntary organizations, was now rapid . . .

Training of Midwives

One of the most important duties of the Central Midwives Board has been to lay down standards for training and qualification of midwives. Year by year since its inauguration, the quality of training has improved and the professional standard of midwives has advanced. The period of training is one year for State Registered Nurses and two years for other women. It is divided into two parts, each with its own examination, a first of six months for State Registered Nurses and eighteen months for others, and a second of six months for everyone. The aims of the first part, spent mostly in hospital, is to provide any pupil midwife, whether she intends to practise or not, with a thorough grounding in the subject under the best available conditions, and that of the second part, spent largely "on the district," is to meet the needs of those actually intending to practise. It has been said that training is constantly under review; like that of the health visitor and the sanitary inspector, and others, it must change and adapt itself to meet new needs. The working party report (1949) on midwives training recommends a year's course (with one examination at the end), of which the first four months is spent in general principles, the second four months in domiciliary midwifery, and the third four months in abnormal midwifery. The great advantage of this will be that the emphasis on domiciliary midwifery and the preventive aspects of midwifery will precede that of the training in abnormal conditions . . .

It has been traditional for domiciliary midwifery in this country to be conducted solely by midwives (approximately 80 per cent). In those cases where a doctor is "booked" to take full charge of the confinement (approximately 20 per cent), the midwife in attendance is termed a "maternity nurse". The National Health Service Act gave every woman the right to a doctor in her confinement free of charge and there has been in consequence an increase in the number of women who look to a doctor from the outset as distinct from cases where a doctor attends only on call. But the distinction between a midwife and a maternity nurse has not, thereby, been altered, and the term "maternity nurse" is still retained for those cases where the doctor takes full responsibility throughout. The midwife retains her original status in all instances where the doctor is booked but reserves his attention to the statutory minimum (a medical examination at booking and at or about the 36th week; a post-natal examination about six weeks after confinement) and when he gives medical attention in addition or during the confinement, only on call. In this capacity, the midwife is still required to fulfil the rules of the Central Midwives Board including regular ante-natal supervision, even if this duplicates that of the doctor.

Where Should a Baby be Born?

We have now to consider the philosophy behind our midwifery services and the reasons which actuate us in establishing a service to meet all needs . . . Should a baby be born in hospital where every modern aid to meet complications can be made available at short notice or should a birth take place at home where there are no immediate facilities to meet complications? In many countries, the answer has been given — in hospital. We in England have continued to advocate home deliveries, partly from innate conservatism, partly from reasons of economy, and partly by an intuitive belief that the atmosphere of the home has much to offer to the newborn babe . . . In any healthy community, homes should be fit for babies to be born into, and to secure this should be one of the fundamental aims of the health authority. Nevertheless, for many years to come, an unsatisfactory environment will force mothers to have their babies away from home and accommodation must always be reserved for mothers with a medical condition which makes close specialist supervision necessary . . . It is well known that hospital confinements, when the mother and baby are maintained free, are cheaper for the patient; only in the matter of government grant (and that recently) does the mother who has a baby at home have any financial advantage over her sister in hospital. In terms of the national exchequer, hospital confinements are more costly . . . A hospital delivery can cost up to £50, compared with less than £20 for a home delivery; and a maternity bed cannot be built and equipped much under £3,000.

It is, of course, undeniable that untoward events do occur in midwifery . . . To meet this and to make home delivery a safe and natural event, the whole midwifery service should be centered upon the home. A well organized service for ante-natal care will reduce to a minimum the occurrence of complications and ensure that all or most women in need of special care will have been removed to hospital. Ante-natal clinics for routine supervision and teaching of all mothers should be supplemented in centres of population by consultant clinics for the few cases of special advice . . .

Institutional care of midwifery is an important part of good maternity service; there must be beds for abnormal cases, preferably in general hospitals and for those normal cases which cannot remain at home. For these latter, accommodation has been made available in three different ways: in the maternity ward in a general hospital . . . maternity homes established by health authorities . . . and private nursing homes . . . The proportion of babies born in hospital is increasing year by year. The present figure is just over 50 per cent as compared with that of 75 per cent officially recommended by the Royal College of Obstetricians and Gynaecologists (which many feel to be too high). About half of the present 50 per cent are delivered in maternity homes or small nursing homes, where the atmosphere is nearer to that of the home than to that prevailing in hospital.

Relation of Doctor and Midwife

This, as we have seen, has never been static but one of development and change to meet new conditions and needs. We have neither followed the steps of our colleagues in the U.S.A., who have seen no purpose for a midwife and where the midwife exists only in negligible proportions, nor that of our nearer neighbours in Scandinavia, where the midwife has been developed to the practical exclusion of the doctor. We have preferred to allow each profession to evolve in its own natural channels, with doctoring backed by maternity nursing for the few who could afford such a luxury, and midwifery backed by doctoring for the many who could not. This balance has been disturbed by the National Health Service Act,

(Concluded on page 88)

The Ambulatory Patient

(Continued from page 31)

diagnostic and treatment procedures necessitating capital expenditure and technical staffing that can be available only in a properly financed hospital or a large and well-equipped clinic. The graduate of the modern medical school has been trained to rely on these services in his professional work. Without them it is impossible for him to apply the diagnostic and therapeutic measures which he considers essential for his patients' welfare. It is most natural that the physician should more and more look to the hospital to make readily available the intricate diagnostic and treatment services required by his ambulatory patients regardless of whether or not they are able to pay their way.

More and more hospitals are recognizing and meeting this obligation to the ambulant paying patient, particularly hospitals in centres large enough to have a well-equipped hospital, but not of a size to support a large clinic.

Tradition and terminology are, however, just as tenacious in hospitals as they are elsewhere. There is no reason why the term "out-patient" should not describe any patient who is housed elsewhere but goes to the hospital for diagnostic or treatment services, rather than such a patient who is unable to pay for services rendered. It is true, however, that a good many hospitals prefer to classify services to paying out-patients under diagnostic and treatment clinics or some similar name. It is entirely possible that the patients themselves desire that such a distinction be drawn.

Regardless of the name used, the important thing is that hospitals are recognizing the fact that the people of their communities, both indigent and those able to pay, and their physicians, must have access as required to the laboratory, radiology, physiotherapy minor surgical, and other services that the hospital has to offer.

Again, the pattern, that better service to the ambulatory patient results in better care for the bed patient, becomes apparent. Extension of diagnostic and therapeutic services to the community at large makes possible better equipment and more adequate staffing.

Home Care Programs

There is a newcomer in the field of ambulatory care involving services that are largely rendered away from the hospital. I speak of the home care programs that might almost indicate the term "ambulatory hospital" rather than "ambulatory patient".

A pioneer in this field was the Montefiore Hospital of New York City under the able direction of Dr. E. M. Bluestone and Dr. M. Cherkasky.

Pilot studies, with the assistance of federal grants, are being carried out at various places in Canada, including the Herbert Reddy Memorial Hospital, Montreal, and the Vernon Jubilee Hospital, Vernon, B.C.

Under the home care program, selected patients are recommended for transfer to their own homes for further care. The patient continues to be a responsibility of the hospital, which supervises his care and maintains complete records. Regular part-time nursing service is furnished, at Montefiore by the Visiting Nurse Service of New York, at the Herbert Reddy Memorial Hospital by the Victorian Order of Nurses, and at Vernon by the Provincial Public Health Nursing Service. Equipment required for home care is drawn from the hospital. Medicines and supplies are requisitioned from hospital stock. Diagnostic and therapeutic services are made available by the hospital. Physiotherapy and occupational therapy play an important part. The patient is visited in his home by his family doctor or by a member of the hospital staff, depending on arrangements made. If the hospital has an intern staff, an intern is usually assigned to the home care program and regularly visits the patients.

If a home care program is to be successful, its prime objective must be rehabilitation of the patient. To illustrate how successful rehabilitation efforts can be and how home care programs can serve the ambulatory patient, I shall quote from a report of Dr. Martin Cherkasky of Montefiore Hospital, New York.

"Jean J. had a growth involving her spine. An operation was performed and a large bony segment was removed. This happened about six years ago. During the intervening time Jean spent more than one year in a body cast and, because of the defect in her spine, was told she could never walk. She was seen in some of the best hospitals, but here was a patient permanently consigned to bed, a hard fate for a 29-year-old girl to endure.

"Eight months ago Jean came on the Home Care Program. She lived in a third-storey apartment with her widowed mother. The doctor, seeing this young woman in her home, developed a much clearer insight into her hopes and desires than could a doctor on the ward where she was just one of a dozen patients bedridden for life. An orthopaedist was called in and, after reviewing all the x-ray films, a special back brace was made for the patient. One day the visiting nurse met the doctor at Jean's home and helped her out of bd with under-the- arm crutches, and so began a long period with the doctor visiting three times a week. the visiting nurse three or four times a week, the physical therapist four times a week, massage, encouragement, new Swiss crutches, leg brace, and one day Jean got out of bed and walked to the bathroom for the first time in over five years. By using telephone books as an improvised stair, she was taught to walk up and down stairs. More than six months after coming on Home Care, Jean walked down two flights of stairs got into a cab, came to our hospital and was presented to our clinical conference. Many of the doctors were surprised to see this 'bedridden' patient come in under her own steam. Jean now is progressing toward walking without any supports."

Conclusion

In conclusion, I should like to speak particularly to the people from smaller hospitals. At times I know you feel that a great deal of what is said and written on hospital topics can be much more readily applied by the large hospital than by the small. In the instance of services to the ambulatory patient, however, you have the satisfaction of knowing that some of the very important services that are now being featured by the large hospitals have long been applied by the small.

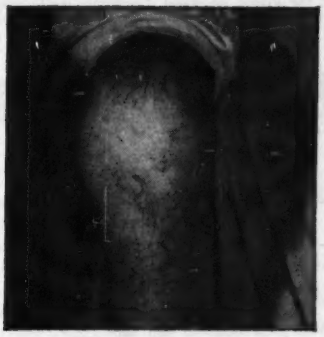
In many smaller communities, for example, every resident turns naturally to the hospital when diagnostic and treatment services are required. No distinctions are drawn between paying and indigent out-patients. Both groups rub shoulders freely in the hospital waiting room and very frequently only the hospital administrator and the office clerk know which accounts are paid and which are written off.

Again, I suspect that there are indeed few small hospitals which have not on various occasions during their entire existence arranged a rooming-in

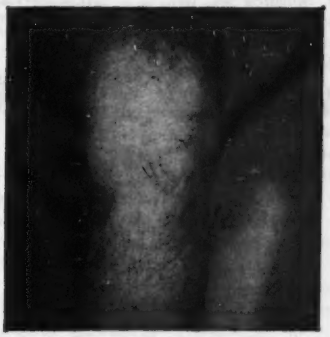
(Concluded on page 86)

Cortone*

Can be used Safely in the Prolonged Control of Rheumatoid Arthritis



BEFORE TREATMENT:
Periarticular swelling and hydrarthrosis



AFTER TREATMENT:
Diminution of pain, increased mobility, and visibly decreased effusion and swelling

Rehabilitation Achieved Through Conservative Dosage

Management in Everyday Practice

The use of simple laboratory tests (sedimentation rates, urinalyses, blood counts, blood pressure and frequent weight recordings), individualized adjustment of dosage, and careful clinical observation will permit most patients to benefit materially . . . without fear of undesired effects.

Effective Antirheumatic Response

Effective antirheumatic response was achieved in all 100 patients in a long-term study at the Mayo Clinic. More than 50 of these arthritics were maintained on 50 mg. or less daily. In no case was it necessary to withdraw the hormone.

Ward, L. E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P.S.: Proc. Staff Mtgs., Mayo Clinic 26: 361, September 26, 1951.

Cortone* ACETATE
(CORTISONE Acetate Merck)

Literature on Request

MERCK & CO. LIMITED
Manufacturing Chemists
MONTREAL · TORONTO · VANCOUVER · VALLEYFIELD

*CORTONE is the registered trade-mark of Merck & Co. Limited for its brand of cortisone.

The Western Institute

(Continued from page 40)

was outlined a pattern of organization for the nursing service, basic principles of administration accompanied by leading questions, and a list of readily available reference materials. It was generally agreed that these small groups "broke the ice" and were responsible for the friendly informality and ready discussion on Tuesday. The break for coffee during each session gave further opportunity for exchange of ideas.

The dynamic, and in spots humorous, demonstration of the nursing team, on Tuesday morning by five members of the staff of the B.C. Division of Tuberculosis Control under the direction of Miss Jean Mitchell, was very enthusiastically received and formed the basis for discussion in both the small groups and in the afternoon session. It illustrated not only how a nursing team functions in giving nursing care but how the planning and evaluation can be a co-operative effort. Valuable reference material prepared by the staff of the Division of Tuberculosis Control was distributed following the presentation.

The reports of group recorders, in highlighting common problems, created such ready discussion that by common consent the entire group remained together for discussion throughout the afternoon.

From the evaluation forms it seems evident that the great majority of those present favoured this type of work conference. Of the 74 evaluation forms returned: 70 indicated great interest and 4 moderate interest; 31 said the conference was of great value; 40 considerable value; and 1 slight value. As to question of time, 52 felt that the time was about right and 20 that the time was insufficient.

Some valuable suggestions have been submitted which will be of help in planning future work conferences of this nature. These covered a wide range of topics, no one topic predominating.

The success of the work conference was due in large measure to the active participation of the members. The reports of the recorders were excellent and indicated the interest and ideas of participants.

At the Wednesday morning session, under the chairmanship of K. K. Reid of New Westminster, B.C., three speakers covered the topic, "Administrative Problems in Connection with the Hospitalization of Long-term Illnesses".

As representatives of the British Columbia Association of Hospital Auxiliaries, this group of ladies made up a committee which nobly undertook and successfully carried through the difficult task of providing entertainment for delegates and guests.

Left to right: Mrs. Forbes Perkins of Vancouver, vice-president of the provincial auxiliaries association; Mrs. S. Cunliffe, Vancouver, Mrs. H. C. McPhalen of Westview, provincial president; and Mrs. C. S. Stigings of Vancouver, treasurer of the association.

In discussing, "Hospitals and Chronic Illness", Dr. L. O. Bradley, Toronto, limited his subject by the use of the following brief definition: "Chronic illness may be described as including those diseases requiring medical or surgical care for periods of six months or longer" (from "Something Can be Done About Chronic Illness" by Herbert Yahraes, Public Affairs Pamphlet No. 176). Dr. Bradley pointed out out that the problems connected with chronic disease are accentuated in those countries which have made the most progress, for fewer of their people die from acute illnesses and may continue to live with resulting handicaps or live on to later decades when they develop disabilities related to the aging process. The speaker quoted U.S.A. statistics to the effect that "one of every six people is chronically ill" and that three out of every four hospital beds are occupied by long-term patients. He urged immediate action to provide a broad and coordinated program based on prevention, treatment, rehabilitation, and research.

Admitting the present reluctance of the acute general hospital to accept long-term patients, since it is geared to a very active diagnostic and treatment program and usually has a waiting list, Dr. Bradley listed other institutions and agencies which are required to care for such patients when the acute phase of illness is passed. These included: the convalescent ward or unit; hospitals for long term diseases (which may well mean three units—for active treatment, rehabilitation, and domicilary care); welfare facilities, *i.e.*, homes for the aged and sheltered workshops; and community agencies which may assist in home care programs. He then enlarged upon the type and functions of the hospital units envisaged, all too few of which exist.

Dr. T. G. C. Caunt, superintendent of the Home for the Aged at Port Coquitlam, B.C., stressed that it is the responsibility of society as a whole to see that our aged spend their days in a productive and satisfying fashion. He defined health as a "state of complete physical, mental, and social well-being, not merely the absence of illness or infirmity" and said that chronic illness in some form was often a direct result of loneliness and discouragement. According to Dr. Caunt, the useful life span should be five times as long as the period of development and the first approach to the problem of how to care for the aged is to make every effort to extend the span. This can be done through prevention, treatment, and rehabilitation. To that end, he deemed it most important that the public at large attain more and better understanding of the geriatric process and forget the once-prevalent idea that people are useless

(Continued on page 70)

The Western Institute

(Continued from page 68)

because they are old.

He classified aged patients as aged, non-senile, senile, and aging psychotic and indicated that rehabilitation schemes for all of them must resemble, as nearly as possible, the home situation. They break mentally if not adjusted to their circumstances. The incidence of aged people admitted to mental hospitals, he said, is twice that of any other type.

Dr. Caunt outlined normal changes after the age of 65 years and the ills which may descend upon older people unless preventive steps are taken. He then described the excellent facilities for the care of the aged now provided at Coquitlam, Vernon, and Terrace, in British Columbia. All inhabitants of these units are screened at Essondale before being channelled to the homes.

In discussing financial and administrative problems connected with chronic illness, Donald M. Cox, Assistant Commissioner, B.C.H.I.S., cited studies of chronic bed requirements which indicated a need for three, four, or five beds per thousand population. He reviewed factors that are likely to encourage prolonged hospital or infirmary stay and pointed out that "in any comprehensive plan for hospitalization of the chronically ill and particularly one geared to pre-payment plans, there would have to be a careful screening of admissions, a regular review of cases, and a systematic and sustained effort to rehabilitate patients to the extent that they could return to employment, if possible, and at least to their own homes or foster homes. Otherwise, the demand would far exceed any estimate of three, four, or five beds per thousand population, and the patient load would be limited only by the number of beds available."

Under the heading, "Active Chronic Care", he explained that in British Columbia, the policy of the B.C.H.I.S. is as follows ". . . if the patient requires the in-patient services of an active treatment or acute general hospital, the case is considered to be acute, regardless of diagnosis or duration of stay. If the patient reaches the stage where he can be adequately cared for in . . . an institution, not providing general hospital care, the case is considered to be no longer acute, and coverage is discontinued."

Mr. Cox then outlined the provision for underwriting the cost of chronic care for needy patients, at the present time, in the western provinces, and the location of long-term hospitals. He mentioned the chronic unit at the Royal Alexandra Hospital in Edmonton and the Princess Elizabeth Hospital (one of the Winnipeg Municipal Hospitals) as good examples of integrating long-term care into existing hospital set-ups.

In connection with home care programs, the speaker referred to the pioneer work of Dr. E. M. Bluestone and Dr. M. Cherkasky at Montefiore Hospital in New York, and to the pilot studies being carried out in Canada, *e.g.*, at the Herbert Reddy Hospital, Montreal, and the Vernon Jubilee Hospital in Vernon, B.C. He pointed out that good home care will never be cheap care but expressed the opinion that "if it can be demonstrated that the interests of good patient care and economy are well served by home care programs, health and welfare authorities would be definitely interested."

Administration

On the morning devoted specifically to administrative problems, Sister Mary Ruth, administrator, St. Vincent's Hospital, Vancouver, illustrated her lecture on the administration of a 100-bed hospital by the projection of slides on a screen. The words, which appeared on the slide were beautifully hand-printed and decorated; some of these read: A hospital —a plant—a living, pulsing organization—dedicated to the amelioration of the ills of people, where life begins, the struggle for good health is fought —and where the soul is aided in its departure to Eternity . . .

In her lecture entitled, "The Heart of the Matter," Sister B. Bezaire of St. Paul's Hospital, Saskatoon, emphasized the moral responsibility resting upon those who are called upon to fill the position of hospital administrator. She said: "This responsibility has very far-reaching effects and the recognition of its role in the details of administration will determine, in a very specific manner, the success or failure of the administrator. This consciousness of our moral obligations is one which will be a motivating force in determining policies, in making decisions, in departmental organization, and in every detail of every action or program we carry on." The speaker mentioned the earnestness with which many authors stress the necessity of obtaining information concerning the patient's ability to pay and other details and she added "let us do the administrative duties but let us not forget that these are a *means* to an end." Again, she stressed that "the patient must get all the care to which he is entitled by need as well as by purchase. Wise economy and control will enable us to stretch the hospital dollar so that the best may be provided for the benefit of the greater number of people—and according to their need."

An educational film showing the advantages of proper maintenance of laundry machinery was highly appreciated by all present. This was shown through the courtesy of Stanley Brock, Ltd.

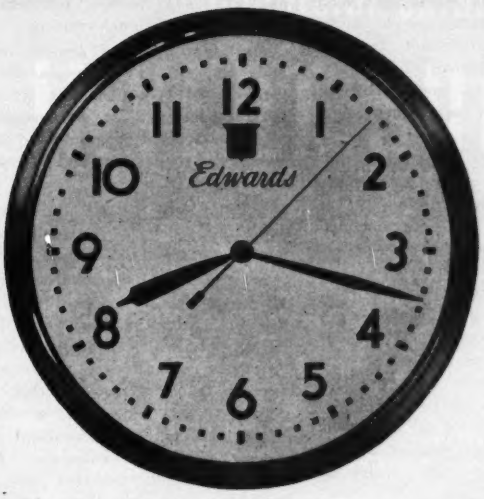
The Hospital and Public Health

In an eloquent and convicing address on the role of the hospital in public health programs, Dr. Angus McGugan of Edmonton, stressed that breadth of vision is required from leaders in the fields of public health and hospitalization. Perhaps, he said, the most oft-repeated prayer in the universe today is for a world united in peace and he added, "there can be no world united in peace as long as starvation and disease take their present-day toll of the teeming millions in the less favoured parts of the world."

The speaker went on to consider what the hospital is doing in the field of preventive medicine and showed that, through routine admission examinations, a diagnostic drag-net is thrown out, leading to the discovery of unsuspected abnormalities. Also, he added, every well-organized hospital has some form of staff health service. "To interest itself further in the public health of the community seems a natural and inevitable function of the modern hospital." Dr. McGugan pointed out that today man's interest in the health of his fellow man is evidenced by a host of voluntary aid societies and that certainly "hospital administrators and trustees may be expected to take their logical place in the front ranks of this vast group who seek to serve mankind in the conquest of disease."

He said the fact that the hospital can be the health centre of a community has often been demonstrated, though such demonstrations have

WORLD'S MOST ACCURATE CLOCK SYSTEM!



NO COSTLY SERVICE CALLS LIKE THIS

Edwards Synchromatic Clock Systems are the simplest, surest ever designed to meet modern timing needs. No master clocks, rectifiers, relays, radio tubes to service or replace. No mercury pendulums requiring semi-annual adjustment. Small wonder Edwards Clock Systems operate year-in and year-out **without servicing or parts replacements.**

Split-second accuracy is *always* available with Edwards Synchromatic Clock Systems because they are controlled by the famous dual, self-starting Telechron synchronous motor. This accuracy is achieved with unequalled simplicity. No master clocks, no temperamental electronic devices, no delicate pendulums requiring service and regulation. Over the years, a service call on an Edwards Clock System is the exception, never the rule.

SIMPLE AUTOMATIC RESET is a major feature of Edwards system. When power is interrupted, batteries keep selected clocks running at correct time. When power returns, dual motors operate remaining clocks at accelerated rate until restored to correct time.

Edwards Scientific Engineering

The masterly precision evidenced in Edwards Program Clock Systems is a product of 78 years of pioneering research and engineering progress. This experience has been applied with equal success to the perfection of such other vital equipment as Edwards Fire Alarm and Communication Systems.

EDWARDS OF CANADA LIMITED
Owen Sound, Ont.

SAINT JOHN — MONTREAL — TORONTO
EDMONTON — CALGARY — WINNIPEG
VANCOUVER

EDWARDS *Synchromatic* CLOCK SYSTEMS

usually resulted from the vision and energy of one individual. To illustrate, he described in some detail the magnificent work done by the late Dr. A. E. Archer of Lamont, Alta. Men like Dr. Archer are rare indeed but, said Dr. McGugan, we must "build our hospital administrators to an ideal pattern, with a lofty conception of the profession of hospital administration." He went on to visualize the hospital and public health organization of tomorrow as a service "wherein practising physicians and surgeons collaborate closely with the medical officer of health and hospital administrators."

Legal Liability

One of the most interesting and important addresses of the week was given by the very able speaker, A. H. J. Swencisky, president of the B.C. Hospitals' Association, when he cited a recent court case in which a large hospital was sued, on a charge of negligence, and the respondent (one who sued) was awarded $40,000. An accident victim was discharged from the emergency department to his home, an appointment having been made with his own physician for the next day. The patient's death, a few days later, was attributed to delay in obtaining treatment. An appeal was dismissed both by the provincial Court of Appeals and by the Supreme Court of Canada, the judgment of which is now final. Mr. Swencisky read from the judge's summary when the appeal was dismissed in order to impress upon his audience the reasoning behind the conclusion that there was negligence. In brief, the intern concerned (an employee of the hospital) "failed . . . in not being more acutely sensitive to the grave symptoms that stood out before him and in not exercising caution against his inexperience, in not seeking verification . . . he was *not* exhibiting the skill and care which the hospital undertook would be exercised in the ward . . . and for that the hospital must answer." The details of the case were enlightening and the whole address a grave warning.

Other Topics

Dr. J. C. Moscovich of Vancouver, presented a brief but humorous and very effective address on "Medical Practitioners and Hospitals." He pointed out again that to give hospital care efficiently, economically, and humanely, requires perfect co-operation between the hospital administrator and the doctor. He stressed that satisfactory relations depended upon good medical staff organization but gave to those present this sage advice: "In your thinking and action do not attempt to mould individuals to a rule; but rather see to it that there is sufficient elasticity to mould the rule to the human (being) . . . Fairness, firmness, and impartiality are the pillars of success in administration."

Speaking on the subject "Professional Standards in Small Hospitals," Dr. Myron Weaver, Dean of the University of British Columbia Medical School, stated his belief that the factors contributing most to high standards are: pride in the institution; the will to work together; good quality of pathological and clinical laboratory services, as well as x-ray service. He stressed that staff conferences were essential and of these the clinical-pathological conference was of inestimable value in attaining and maintaining high professional standards.

Dr. T. H. Patterson of Victoria, who is chairman of Civil Defence Services for British Columbia, outlined the defence health services planned for that province and discussed progress to date. In a brief address on "Canadian Hospital Organizations", Dr. L. O. Bradley, executive-secretary of the Canadian Hospital Council, described the network of associations, conferences, and councils across Canada and stressed the value (to hospitals and the public) of the work accomplished by these organizations.

A general round table session on Friday elicited innumerable questions and fast discussions. Students and visitors were able to place before the meeting specific problems and, even where no definite answer could be given, they at least received the benefit of opinions expressed. Members of the institute teaching staff answered questions and Percy Ward acted as interlocutor. Throughout the entire program, short discussion periods were held after each session and students took full advantage of these to ask questions.

Even before the Seventh Western Institute had finished, the Central Co-ordinating Committee met to consider plans for the 1953 event. Those present were: Alberta—Dr. Angus C. McGugan, and Leonard Wilson; British Columbia—A. H. J. Swencisky, Percy Ward, and Harry Baxendale; Saskatchewan — G. E. Barton, John Smith, and E. V. Walshaw; Manitoba — P. D. Shannon and John McIntyre; and Dr. L. O. Bradley, representing the Canadian Hospital Council.

Discussion revolved around three main topics: (1) a campus setting versus hotel accommodation for the next institute; (2) a convention or workshop type of program or a combination of these types; and (3) space for exhibitors.

In 1951, Alberta, through force of circumstances, held its institute on the University of Alberta campus. The event proved so popular that British Columbia decided to hold its 1952 institute on the campus of the University of British Columbia. Those favouring a university environment for institutes represented that the university provided a quiet academic atmosphere and an environment conducive to a good attendance, both at the academic sessions and the exihibts. Those who have not been so impressed by the university environment pointed out that there is considerable inconvenience due to the fact that universities are usually some distance from the centre of the city and present transportation and accommodation problems. Exhibitors are inconvenienced since they are not able to return to their offices or keep appointments while general sessions are in progress. On a show of hands, the majority of those present seemed to favour holding the institute in a hotel. It was decided that each province would make its own decision in the matter.

With respect to types of program, it was agreed that the combination of work conference and general sessions seemed to be most acceptable to students and staff. It was also the opinion of this group that there should not be too many work conferences since delegates frequently want to attend two or three events which are in progress at the same time. Further, delegates prefer the variety provided in general sessions. A motion was passed to the effect that, as usual, the actual program should be left in the hands of the province responsible for the institute. Appreciation of the contributions of the exhibitors was

(Concluded on page 97)

Medical Staff By-Laws

(Continued from page 42)

(a) Clinical oversight of all patients.

(b) Advisor to the superintendent in matters affecting techniques, patients, service, and the like.

(c) Responsible for all matters affecting the medical standards of the hospital.

(d) Responsible for the inter-relations of departments and services to form the most efficient unit.

Regular monthly meetings of the staff must be held. It is essential that all committees function and bring in their reports at the monthly meetings. This is a "must". Once there is any relaxation on the part of the chief of staff in allowing committees to delay reports, deterioration is setting in.

The monthly reports shall be given by the chiefs of the various services who make comments, recommendations, and criticisms. Afterwards, there shall be active discussion. If the morbidity and mortality rates are going up, if autopsies are falling off, if there are too many Caesarean sections, if there are too many normal pathology reports — all of these situations should be investigated and appropriate action taken.

Any violation of the by-laws, rules, and regulations of the hospital shall be reported to and investigated by the credentials committee who shall report to the medical executive committee. The doctor involved shall be notified in writing and have the opportunity to appear before the committee in his own defence. These violations shall be reported and appropriate action taken. If this is done, you will find a concerted effort on the part of every member of the medical staff to make a diagnosis, then have consultations, and carry out proper treatments whether medical or surgical.

All patients admitted to the hospital shall have a provisional diagnosis followed by a proper history and medical examination. Treatments, tests, operations, and progress notes, shall be properly recorded and the record completed as soon as possible after discharge, *i.e.*, 24 hours. The medical records and program committees shall report any members to the medical staff for disciplinary action.

There should be regular, organized, clinical-pathological conferences and ward rounds.

Qualifications for Membership in Departments

In reading the by-laws of various hospitals it is interesting to observe how well the specialist has protected himself. This, no doubt, is very essential and I presume it is done to maintain a high standard of medical care. The idea of having a general practitioners' section in hospitals is, I think, a good one but such a section may take some time to organize properly. In small hospitals, establishing standards of qualification is much more difficult and I think that those doctors who are qualified have a duty and an obligation to see that the less experienced members of the staff are properly trained. To adopt a standard of qualification to govern the practice of surgery is a very delicate and often a long-drawn-out procedure. At our hospital we are in the midst of such a problem. There is no question about appointing, to the surgical staff, members who hold qualifications such as fellowships or certifications. The difficulty arises in governing those who have had one or two years of training and are doing a general practice, including surgery. At the present time this is being controlled in our hospital by the chief of the surgical service. We require that a qualified man must act as an assistant at operations; that he must fill out a consultation report on the patient including the findings, diagnosis, and recommendations; and that it is his responsibility to see that the operation is carried out in a satisfactory manner.

In the past the surgeon has monopolized the professional and financial fields of medicine to such an extent that he feels that he is a kind of super-being. He does not ask medical confrères for consultation often enough. I have a medical consultation on practically every operative procedure and I use them not only pre- but post-operatively, too. I think that the surgeon is beginning to realize that it is not only *his* knife and ability that save lives but that the medical men and the anaesthetist deserve, on some occasions, most of the credit. The latter are gradually but slowly coming into their own. Some way should be worked out so that these men would obtain a more equal dis-

(Concluded on page 90)

THE CANADIAN HOSPITAL

The Canadian Hospital is published monthly by the Canadian Hospital Council as its official journal devoted to the hospital field across Canada.

The subscription rate in Canada, U.S.A., and Gt. Britain is $3.00 per year. The rate for each additional subscription to hospitals or organizations having a regular subscription (and personal subscriptions for individuals directly associated with them) is $1.50 per year. The rate to other countries is $3.50 per year. Single copies, when available, are supplied at 50c each.

Le Bureau d'Admission

(Continué de la page 44)

cialistes de l'hôpital en vue de mon plus grand bien"; semble suffisante pour autoriser toute intervention sans autre signature.

La carte d'enregistrement une fois complétée, est inscrite dans un registre spécial. Cette carte est numérotée et doit correspondre aux fiches des statistiques. Le but essentiel de ce registre est de s'assurer du nombre exact de cartes et de voir à ce qu'aucune n'ait été omise ou écrite en double. A l'aide de cette carte le bureau d'admission procède à la préparation de la fiche pour le malade. Sur cette fiche de dimension de 8½ x 11 et qui consitue la première feuille du dossier du malade, sont inscrits le nom, l'âge, l'adresse, l'occupation du patient; le nom du médecin traitant et de celui qui a recommandé le malade; la date d'admission, le numéro d'hôpital et celui du registre. Une copie de la fiche est remise immédiatement au département par la personne qui accompagne le patient, à l'interne du médecin traitant, au laboratoire, aux rayons X d'admission pour cliché pulmonaire, à la diététiste et l'original aux archives. Une baguette spéciale contenant le nom, l'adresse, l'âge du patient, le numéro de son lit ou de sa chambre, ainsi que le nom de son médecin est remise, dès l'entrée du patient, au bureau de renseignements pour être insérée dans le Kardex destiné à cette fin. La carte d'enregistrement est remise au bureau des compte et immédiatement est ouvert au nom du malade un compte qui restera en filière jusqu'à son départ. Toutes les semaines à un jour déterminé, soit un mardi ou un autre jour, ce compte sera envoyé au malade.

Pour fins de statistiques et de renseignements, la carte d'enregistrement est classée dans une filière alphabétique et conservée pour le moins dix ans.

L'hospitalière doit être très fidèle à distribuer les malades publics dans leurs services respectifs. Etant donné le nombre considérable de médecins traitants dans un grand hôpital, il est de son devoir, lorsqu'il s'agit d'assistance publique, de répartir avec l'aide du directeur médical tous les malades de façon juste et équitable.

Parfois un hôpital, même reconnu général, n'inclut pas toutes les spécialités médicales et chirurgicales. En certaines villes, les maladies contagieuses sont centralisées au même hôpital. L'obstétrique se pratique dans la plupart des hôpitaux, mais le psychiatrie a souvent son centre spécialisé. Toutes ces divergences sont acceptables et il est du devoir de l'hospitalière de bien connaître la classification de son hôpital et d'observer les lois qui le régissent. Dans un avenir très rapproché, il sera de routine d'assurer à tous les maladies hospitalisés, une radiographie des poumons. A cet effet, une pièce à proximité du bureau d'admission, renfermera les appareils nécessaires. Une infirmière technicienne sera autorisée à recevoir les malades. Comme aucune préparation antérieure n'est requise, le malade ambulant, sitôt son enregistrement complété, subira ce premier examen.

Les mesures prise par la Ligue Antituberculeuse méritent certes notre encouragement. Grâce au dévouement inlassable d'infirmières compétentes et spécialisées, le dépistage de la tuberculose devient facile et la guérison assurée.

L'enregistrement comporte beaucoup d'autres formalités non moins importantes. Celle par exemple de savoir, dès l'admission du malade, s'il possède une assurance-maladie. Certaines assurances requièrent un avis d'admission; ainsi en est-il des Services de Santé du Québec, de la Mutual Bénéfit, de la Croix Bleue, au nom si connu, qu'elle appartienent aux Etats-Unis, à l'Ontario, au N.B. ou Québec. Toutes ces compagnies exigent un diagnostic provisoire de la maladie dès l'arrivée du patient à l'hôpital. Un avis de l'hospitalisation du malade avec le diagnostic doivent donc être adressés à ces divers bureaux dans le plus court délai.

Quant aux autres assurances, on doit noter sur la carte d'enregistrement le nom de l'assurance, à titre d'indication du mode de paiement au bureau des comptes, et exiger une signature autorisant le paiement direct à l'hôpital. Très souvent le souscripteur a, en sa possession, cette carte d'identification qui autorise le paiement à l'hôpital.

La liste d'admissions des patients, celles des départs et le (Daily Census) pourcentage quotidien d'hospitalisation, doivent être rédigés tous les matins et conservés en filière afin de les produire lors des visites de l'hôpital et aussi en fin d'année pour les statistiques.

Quant à la liste des départs et des transferts, ces deux rapports doivent être copiés en triplicata ou davantage pour être remis aux renseignements, aux archives et au bureau des comptes.

La surveillance d'un service où s'effectue un transfert doit, à l'arrivée du malade:

(1) Vérifier son dossier et inscrire le nouveau numéro de chambre en ayant soin de biffer l'ancien;

(2) Donner avis du transfert à la diététiste ainsi qu'au laboratoire;

(3) S'assurer que la liste des vêtements, habits, est complète et signée par le malade. L'expérience a maintes fois démontré combien il est important de vérifier cette liste si on ne veut, au départ du malade, avoir à créditer des comptes à cause d'un manteau ou d'un complet disparu.

(Continué à la page 78)

Institute on Aseptic Techniques Held in Kitchener, Ont.

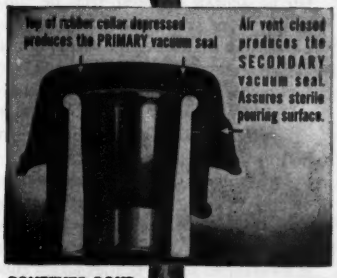
The first Canadian institute on operating room, central sterile supply and blood bank techniques opened at the Kitchener-Waterloo Hospital, Kitchener, Ont., on April 28th. The institute was sponsored by the Canadian Hospital Council with the hospital acting as host to the registrants.

The week-long course was attended by 50 registrants from Canada, United States, and Brazil. Dr. Carl Walters, assistant professor of surgery at Harvard University, and senior associate in surgery, Harvard Medical School, presented the lectures and was assisted by Miss D. Wysocki of the nursing staff of the Peter Bent Brigham Hospital, Boston.

The entire week was fully occupied by intensive lectures and demonstrations, accompanied by slides and a moving picture concerning operating room procedures. Lectures covered subjects such as sterilization by chemicals, steam and hot air, disinfection of the skin, care of instruments, operating room and blood bank techniques, and organization and operation of a central supply department. The lectures were broken only by a "free period" during Wednesday afternoon during which registrants were taken on conducted tours of the hospital. They also enjoyed sight-seeing in and around the city and visited several local plants.—*F. M. Donohue, R.N.*

Only POUR-O-VAC SEALS

afford a practical means of avoiding a wasteful, inconvenient, time-consuming and questionably scientific method of sealing and handling your supply of surgical solutions . . . and routinely checking the sterility of contents during long storage periods without breaking the hermetic seal.



CONTENTS POUR FROM A STERILE LIP

. . . and with it goes

1. **Supply Conservation** . . . provides dustproof seal for remaining fluid when only partial contents of a container are used.
2. **Supply Conservation** . . . eliminates need to utilize gauze, cotton, paper, string or tape to effect makeshift seal of questionable efficiency.
3. **Supply Conservation** . . . reduces possibility of breakage or chipping damage to lips of Fenwal containers.
4. **Supply Conservation** . . . POUR-O-VAC SEALS* are reusable . . . may be sterilized repeatedly . . . interchangeable for use with 500, 1000, 1500, 2000, 3000 ml. FENWAL containers.

*A product of Fenwal Laboratories, Inc.

ORDER TODAY or write us for detailed information

MACALASTER BICKNELL COMPANY
243 Broadway Cambridge 39, Massachusetts

THE Stevens COMPANIES
Exclusive Distributors—
Toronto, Winnipeg, Calgary, Vancouver.

THE SOLUTION DESIRED — THE Fenwal SYSTEM — AT THE INSTANT REQUIRED

Le Bureau d'Admission

(Continué de la page 76)

Lorsqu'une demande de transfert est requise pour les hôpitaux spécialisés, tels que: chroniques, convalescents, T.-B., elle doit être signée par le médecin traitant et remise au bureau d'admission. Cette demande peut se faire verbalement entre bureaux d'admission. Cependant un résumé du dossier du malade doit être immédiatement rédigé et accompagner la demande de transfert adressé soit au directeur médical, soit au bureau d'admission.

Les services d'ambulance sont sous le contrôle du bureau d'admission. En ce qui concerne les accidents de rue, chaque hôpital a ses directives et il est essentiel de les suivre.

L'enregistrement par téléphone est, sans contredit, très appréciable. Il diminue énormément le travail des formalités à remplir à l'arrivée du malade et libère, par conséquent, ce dernier beaucoup plus rapidement.

Régulièrement vers 4 heures de l'après-midi, le bureau d'admission reçoit la liste des opérations du lendemain avec le numéro du patient, le diagnostic, l'heure de l'intervention, le nom de chirurgien, de l'assistant et de l'anesthésiste. Le bureau d'admission étant, comme nous l'avons dit au début, le coeur même de l'hôpital, et ayant à traiter continuellement avec les médecins, il est essentiel que cette liste soit placée en vue de tout son personnel pour le renseigner au besoin.

Le bureau d'admission ne semble plus l'endroit destiné à fournir aux parents et aux amis des malades, des informations sur leur état; cela revient de droit au Bureau de Renseignements. Les officières des divers services y envoient régulièrement des notes exactes sur l'état du malade: patient opéré, et caetera, et les personnes en charge de ce bureau donnent les détails demandés.

Décès des Malades

Immédiatement après un décès, on doit prévenir le bureau d'admission et y conduire dans le plus court délai, les proches parents du défunt. Pour fins scientifiques de recherches ou d'études, il est dans l'intérêt de l'hôpital de demander le post-mortem. On doit s'insinuer si délicatement et avec un tel tact pour obtenir l'autorisation des parents, que les coeurs pour lors profondément affligés, n'en soient ni blessés, ni endoloris. Faire connaître le pourquoi de cette intervention posthume est souvent le moyen le plus efficace pour obtenir le consentement désiré. Cependant, cette requête qui se renouvelle fréquemment, n'en demeure pas moins très pénible et requiert de la personne qui s'aquitte de ce mandat, autant de sympathie que de doigté et de cordiale charité.

Lorsque pour une raison quelconque le P.M. est refusé, le chef-interne ou le sénior de garde est appelé pour préparer le certificat de décès. Le corps du défunt est alors déposé à la chambre mortuaire jusqu'à l'arrivée de l'entrepreneur. Ce dernier doit se présenter au bureau d'admission. Lorsqu'il a apposé sa signature dans le cahier affecté à cet usage, le permis de sépulture et le certificat de décès lui sont remis. Un portier est chargé de l'accompagner à la chambre mortuaire pour livrer le corps.

Si les habits du défunt n'ont pas été réclamés par la famille, on les confie à l'entrepreneur qui met, cette fois, sa signature sur la liste des habits; cette dernière est remise au dossier du malade.

Les décès survenus à l'hôpital, en moins de 48 heures d'hospitalisation, doivent être soumis au coroner. Dans l'occurence, c'est à lui à déterminer les procédures à suivre.

Aucun malade ne doit sortir de l'hôpital durant son séjour d'hospitalisation sans une autorisation écrite à son dossier, et la surveillance de l'étage doit en avertir le bureau d'admission.

Le médecin traitant doit lui-même signer le congé du malade au départ, et signer également le dossier, *i.e.*, inscrire le diagnostic final. Le personnel de l'étage s'empressera de faire parvenir le dossier au bureau des comptes et de mentionner les divers départements possédants certains comptes: laboratoire, pharmacie et caetera On ne saurait apporter trop de diligence sur ce point, car il est regrettable d'avoir à adresser des comptes aux malades, alors que ceux-ci croient avoir tout soldé avant leur départ de l'hôpital. On peut même, par là, diminuer considérablement l'estime qu'ils avaient de l'institution.

Le personnel du bureau d'admission, comme nous venons de l'exposer, assume de lourdes responsabilités. Ses relations avec le public, les médecins et les malades sont si fréquentes qu'elles exigent de sa part, une continuelle réserve.

Que la religieuse en charge de cet office soit attentive à se surveiller elle-même tout autant que son personnel car, ne l'oublions pas, tout ce qui se discute et se résout en ce bureau d'ad-

(Suite sur la page 80)

A.C.H.A. Undertakes Program of Revolving Scholarship Loans

Revolving scholarship loans, to encourage deserving persons to pursue or further careers in hospital administration and to contribute to the improvement of hospital administration generally, are now being made available by the American College of Hospital Administrators. The loans, believed to be the first of their nature in the field, will be offered both non-affiliates and affiliates of the College. The awards will make it possible for candidates, who might not otherwise be able to prepare for careers in hospital administration, to take courses at some 13 universities where it is taught.

Through this new project, the general plan of the College is to make limited sums available annually to persons in the hospital field, who will agree to repay the amounts on terms established by the College's Scholarship Committee. Candidates for loans are required to have a baccalaureate degree or its equivalent in education or experience and have a desire to better prepare themselves in hospitel administration. The fund is also designed to assist financially those persons planning to undertake a program of formal study and who have been accepted or are presently enrolled in a course of hospital administration acceptable to the A.C.H.A.

Basis of the new awards will be primarily scholastic attainment or experience and the considered worth of the student's proposed field of endeavour in one of such study areas as hospital administration, public health, medical economics or other allied fields as approved by the scholarship committee, which will administer the revolving scholarship fund. Further information and application forms are available upon request to the American College of Hospital Administrators, 22 East Division Street, Chicago 10, Ill.

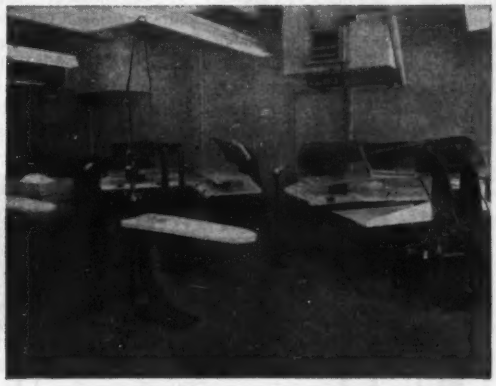
Canada's Most Modern Hospital Laundries use GOLDEN XXX PURE SOAP

Peterboro, one of Ontario's most progressive cities, is justly proud of the New Civic Hospital just completed.

The laundry in this modern new hospital is a model in every respect. Their equipment is of the latest design, the floor plan is carefully thought out to eliminate all unnecessary steps. This combination of up-to-date equipment, latest laundry techniques and extremely workable floor plan layout is already producing high quality laundry work.

Of course, Golden XXX pure soap is the logical choice, and Golden XXX has been specified, as it has been for many years in the former Peterboro Civic Hospital.

Colgate congratulates the city of Peterboro, and especially all those citizens responsible for the erection of this modern new hospital.



CANADA'S LEADING LAUNDRY SOAP

May we suggest that you contact our nearest office for prompt service.

MEMBER CANADIAN

Colgate-Palmolive-Peet Company, Limited
64 Colgate Ave., Toronto 8

ST. JOHN'S MONCTON QUEBEC CITY MONTREAL OTTAWA WINNIPEG REGINA CALGARY VANCOUVER

Coming Conventions

July 24-26—Fifth Annual Conference on Aging, University of Michigan, Ann Arbor.

Sept. 3-6—Annual Convention of the Canadian Society of Radiological Technicians, Palisser Hotel, Calgary.

Sept. 15-18—Annual Convention of the American Hospital Association, Philadelphia, Penn.

Oct. 7—Annual Convention of the Catholic Hospital Conference of Saskatchewan, Saskatoon.

Oct. 8-9—Saskatchewan Hospital Association Convention, Bessborough Hotel, Saskatoon.

Oct. 16-18—Associated Hospitals of Alberta Convention, Palliser Hotel, Calgary.

Oct. 22-24—Associated Hospitals of Manitoba Convention, Royal Alexandra Hotel, Winnipeg.

Oct. 27-29—Ontario Hospital Association Convention, Royal York Hotel, Toronto.

Oct. 30-31—Annual Convention of the Ontario Conference of the Catholic Hospital Association, St. Joseph's Hospital, Toronto.

←

mission a une répercussion dans tout l'hôpital. Que sa confiance soit grande en Celui qui récompense un verre d'eau froide donné en Son Nom: qu'elle n'ait d'autre idéal que le Christ, modelant sa charité sur la Sienne. Diplomatie et tact lui inspireront alors au moment opportun les paroles qui pacifient, qui encouragent, qui consolent.

Les médecins, membres actifs du bureau médical, ont de droit les premiers, le privilège de faire entrer leurs malades à l'hôpital. Il est bien entendu que la religieuse en charge du bureau d'admission exerce une surveillance active sur l'admission des patients et fait tout son possible pour donner à chacun entière satisfaction. Bien des facteurs cependant entravent ses projets et pour n'en mentionner qu'un, signalons le plus pénible, celui qu'on voudrait n'avoir jamais à invoquer: le manque de place! Donnons du moins à nos médecins, à ceux qui se dévouent sans compter, notre confiance et notre encouragement. L'unique idéal que tous nous avons à coeur de réaliser, est bien celui "du soin des malades". Il est beau, il est grand et devant lui aucune opposition, aucune divergence d'esprit ne saurait tenir. Unissons-nous donc hospitaliers, hospitalières pour travailler et à la santé de l'âme et à celle du corps.

On a écrit quelque part que "le morceau de pain donné au pauvre, c'est déjà beaucoup mais la nourriture de l'âme, de l'esprit et du coeur est d'une valeur infinie". Ce qu'une femme de lettres a pu affirmer, réalisons-le dans notre vie.

Habituons-nous à être cordiales, gracieuses, condescendantes! Soyons généreuses, car le charité ouvre la porte aux largesses divines. Observons ce programme et la joie, une joie douce et sereine sera notre récompense! ●

DIEHARD'S CASE ISN'T SO UNUSUAL AFTER ALL! In all types of industry West representatives hear comments like "our situation is a special one" . . . "an insecticide is bound to impair the quality of our product" . . . and – stranger still – "we don't have any insect problem here!"

VAPOSECTOR was formulated for the realist who *has* an insect problem and wants to get rid of it – fast! It's fully three times as concentrated as the standard Grade AA spray . . . yet there's no danger of contamination or odor when used according to directions. Vaposector controls insects by "double penetration". When used with West spraying equipment, it becomes a "dry fog" that *penetrates* the most remote crevice . . . then *penetrates* the insect's outer covering for a permanent kill. There's no place to hide. No time to escape. A Vaposector demonstration has often revealed dead insects in numbers never thought possible – simply because they live and multiply in unseen cracks and crevices.

VAPOSECTOR gives more positive control value per gallon than any competitive product. It breaks down into such minute droplets when atomized with specially-designed West equipment, that only one ounce is needed to control flying insects in 1000 cubic feet . . . only two ounces for crawling insects. Compare it with an ordinary mill spray and you'll find Vaposector is over *four times as economical in use!* West can supply Vaposector as well as special mill sprays and fumigants . . . residual and contact insecticides . . . spraying equipment – a *complete insect control program* tailored to your exact needs!

WEST DISINFECTING Co. Ltd.

5621-23 Casgrain Ave., Montreal, Quebec
(Branch Offices: Calgary, Edmonton, Halifax, Regina, Toronto, Vancouver, Winnipeg)

ASK FOR FURTHER INFORMATION ON HOW TO CONTROL INSECTS BY "DOUBLE-PENETRATION"

Dept. 22

☐ Please send Vaposector booklet.

Please send information on specially-designed permanent ☐, portable ☐, hand spraying ☐ equipment

Name _____ Title _____

Company _____

Address _____

City _____ Province _____

Hospital Construction

(Concluded from page 48)

inside. In smaller cities, (and therefore smaller hospitals) where the windows are cleaned in the spring and fall, the ordinary double-sash type may be sufficient. When these windows are cleaned, the patient does not have to suffer the inconvenience of draughts, as the outside of the window has to be cleaned from the outside.

In this part of North America, an air conditioning system is necessary only for the nurseries, operating and delivery rooms, and the dietary department. The nurseries and operating rooms should have humidifying equipment.

For stairways or sections of stairways which escape the brunt of traffic, mastic tread-filler is excellent and the cost is about half that of terrazzo. If linoleum is used on corridors, small sections can be laid over the main floor in areas of heavy traffic such as at counters, doors, et cetera. Sections can be replaced without the necessity of re-covering the whole floor.

In smaller hospitals, an elevator maintenance contract can save much trouble and expense. Even some of the larger hospitals would do well to consider this unless they have a maintenance engineer well versed in this type of equipment.

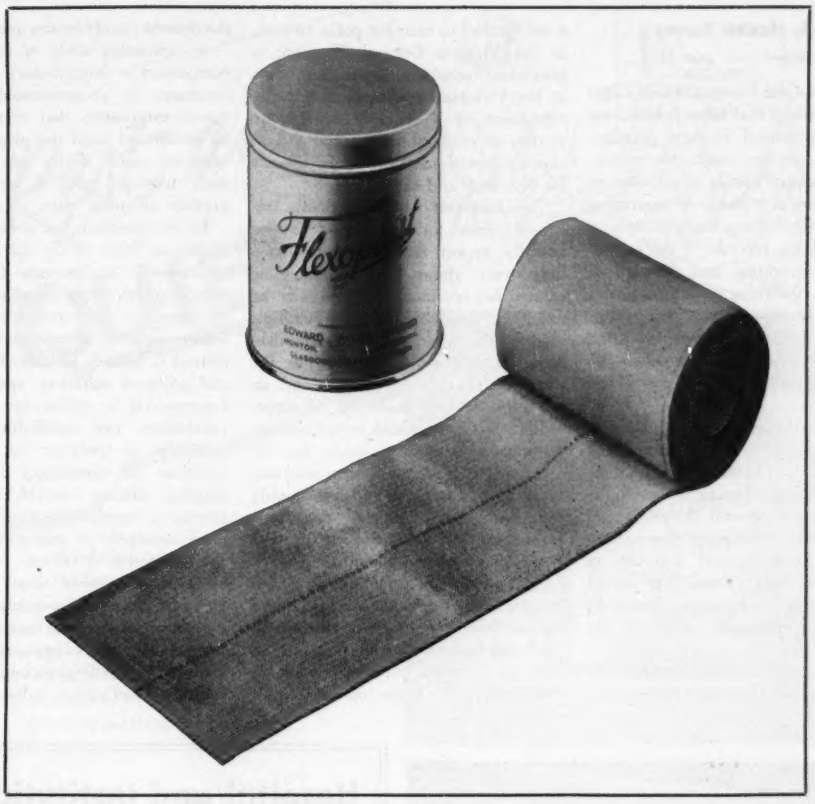
A few electrical outlets will be 220 volts. Although attention can be drawn to these outlets by a coloured wall plate or by stencilling 220 v. in red, as long as we are dealing with the human element, the safest way is to have a three-pronged polarized locking plug. Other plugs will not fit into the outlet. Where oxygen equipment and floor polishing machines are used, 110 volt outlets should be polarized. This should be done in the laboratory, too, since there is a real danger of causing a short circuit where there is so much moisture. Where fluorescent lighting is used, commercial fixtures are good for workrooms, dietary, and similar departments.

In decorating, it is wise to limit the range of colours to be used. Cool colours are excellent for rooms on the sunny side of the hospital and warm colours brighten the north and east sides.

We like the glass walls at the end of our corridors. Besides reflecting the natural light, they lend themselves admirably to the artistic skill of the student nurses at Christmas.

Storerooms should be centralized and as near the delivery entrance as possible. If you are not in favour of one large store-room, there could be three separate rooms; one for food stores, another for dressings, surgical sundries, and stationary; and a third for cleaning materials, toilet sundries, drums of soap and cleanser, and washing compounds.

It is an excellent idea to ask consultant engineers to examine the hospital's water as to hardness and long-term effect on plumbing lines. When oxidation in our steam return line was causing rapid deterioration, we were informed that we would need an acid softener unit in addition to the standard softening equipment. This amounted to approximately $4,000 in cost but what is still more serious is the unestimated damage which has been done to the various lines. ●



THE IMPROVED

FLEXOPLAST

ELASTIC ADHESIVE BANDAGE
with the NON FRAY EDGE

Each strip of Bandage Fabric is woven separately with individual control of thread tensions.

The improved Non Fray Edge provides the Advantage of a Bandage which will lie flat on the Limb.

By reason of the Greater Softness of Doubled Thread, the Flexoplast Fabric is more impermeable to the Adhesive spread, is cleaner on the back and softer and more flexible in use.

THE Stevens COMPANIES

TORONTO WINNIPEG CALGARY VANCOUVER

N. S. Health Survey

(Continued from page 52)

report quotes the Dawson Royal Commission findings that these institutions have fallen behind modern practice. The health survey committee recommends an annual survey of all cases in county homes as a means of separating normal inmates from the psychotic, a clean-up of the records of the county homes and hospitals, and a review of legislation concerning committal to and release from these municipal institutions. The report recommends that the county institutions be replaced by regional hospitals with psychiatric sections.

The report urges a "high priority" for a cancer control program; suggests that a modern cancer clinic for deep x-ray and radium therapy be developed at the Victoria General Hospital; that one general practitioner from each town be given special training in diagnosis of cancer; and that cancer detection and consultation clinics be set up in different parts of the province.

Recommendations are included for a communicable diseases section, with a sub-section to care for polio victims, at the Victoria General Hospital; a provincial rehabilitation centre, also at the Victoria General Hospital; development of a training school for victims of cerebral palsy; and expansion and modernization of the schools for the deaf and the blind.

The hospitals of Nova Scotia received praise for their good service and the report states that the more than two dozen recommendations offered are not meant to minimize the excellent contribution which has been made. The report suggests establishment of a hospital division in the provincial health department and an advisory council made up of representatives of interested organizations. A recommendation is made that all general hospitals should be graded and inspected regularly in order to qualify for provincial financial assistance. Licensing and inspection of nursing homes is also recommended.

A system of priorities for new hospital construction is suggested and the committee urges negotiations with the municipalities for creation of regional hospitals for the care of the chronically ill. These would replace the present county homes and hospitals.

A continuing study of a system of compulsory, contributory hospital insurance is recommended but the report emphasizes that it should not be introduced until the physical facilities are more nearly adequate and until nursing staff is available to provide adequate care.

In its comments on general public health in Nova Scotia the committee recommends an increase from eight to nine or ten in the number of health divisions in the province. One of these would be a metropolitan health district to include Halifax, Dartmouth, and adjacent suburban areas. It also recommends a review of quarantine regulations and notifiable diseases, asks the co-operation of organized medicine in stimulating interest in venereal disease control, and urges provincial legislation to enforce minimum standards of sanitation of milk, water supplies, et cetera.

An "indisputable" need for more nurses is noted in the section covering nursing facilities and nursing education and the report urges capital grants to aid in providing training facilities for nurses and nurses' aides and annual

grants to help meet the costs of training programs. The report terms the nursing aid "a bright spot for the future" and recommends that the Atlantic provinces share proportionately in training this group.

The committee comments that most of the infant deaths and still-births in Nova Scotia result "from causes which are to a large extent preventable" and urges development of a co-operative program involving physicians and public health nurses, and an improvement in obstetrical facilities in hospitals.

Other recommendations include: (1) more extensive training of teachers in health matters and a revision of methods used by school doctors and nurses in giving health examinations to school children; (2) provision of consultative services for hospital laboratories; (3) the training of more dental hygienists; (4) development of school dental health programs, with the cost shared by the province and the municipalities; (5) more health education and more research into public health problems; (6) extension of the program of travelling clinics for crippled children and development of a co-operative program with voluntary organizations for a modern program of aid to crippled children; (7) extension of the program of routine chest x-rays for all persons admitted to hospital; and (8) an extension of the rehabilitation program for persons discharged from sanatoria.

Ambulatory Patient

(Concluded from page 66)

maternity service to meet a sudden need or emergency.

I have known more than one small hospital that, because of the intimate acquaintanceship between patients and hospital, found ambulatory patients anxious to undertake some of the less involved duties within the hospital to the mutual benefit of both the patients and the hospital.

Though small hospitals lack the highly specialized facilities of the metropolitan hospital, it will often surprise you to list the services in the form of treatment rooms, simple physiotherapy, sunrooms, up-patient dining rooms and beneficial occupational or diversional activities that can be planned and set in operation for the ambulatory inpatient. The lack of specialized direction from a physical medicine department can be offset by joint conference and study on the part of the medical staff and matron, fortified by intimate knowledge of the patient, to work out programs that will prove of real and lasting benefit to the ambulatory inpatient.

Finally, although it happens that abrupt trends are often followed by some recession (and it may be so of early ambulation) there seems little doubt that the ambulatory in-patient will remain a permanent feature of the hospital picture.

Hospitals on this continent have invariably risen to meet every challenge offered by advances in medical science. There is no reason to imagine for a moment that the challenge of service obligations to the ambulatory patient will not be accepted and met by hospitals large and small.

Monopoly is like a baby—a man is opposed to it on general principles until he has one of his own.—*The English Digest.*

ATRALOC* *Needle Sutures*

For the Surgeon...

ATRALOC provides outstanding conveniences:

- minimal tissue trauma — needle carries single strand
- improved points and constant sharpness
- longer, more useful flat area — needle won't turn in holder
- saves time of needle threading
- eliminates unthreading during operation

For the Hospital...

ATRALOC effects appreciable economies:

- minimizes needle inventories — fewer sizes and varieties needed
- saves nurse hours
- simplifies replacement problems
- eliminates needle preparation (cleaning, washing, sharpening)

SPECIAL ADVANTAGES OF ATRALOC SEAMLESS NEEDLES

ATRALOC Seamless Needles are needles of choice for general closure, obstetrics, gynaecology and most procedures where catgut is indicated. They have a single temper throughout — optimal flexibility and uniform strength without soft spots or brittleness.

ETHICON SUTURE DIVISION

Johnson & Johnson
LIMITED MONTREAL

*Trade Mark

Midwife in Britain

(Concluded from page 64)

so that it is important to examine just what each stands for and in what relationship to each other. The advantage of the full primary responsibility resting with the physician lies in the importance which this has had for his position as "family doctor," coupled with his ability to deal directly with abnormalities, and emergencies, his greater resources in analgesics and anaesthetics, his greater prestige, and the ready access which he has to consultants and hospitals. On the other hand, the present number of family doctors is quite insufficient to handle all births in this country and with his present commitments, it is doubtful whether the doctor can handle any appreciably greater number than the present 20 per cent. The midwife with full primary responsibility can offer the incomparable advantage of time, in marked contrast with the doctor whose time is generally limited and who has conflicting duties . . . For the midwife, the normal delivery is her life's work and she acquires great skill and experience in its management; her attention is focused on the physiological process and not upon illness nor unduly on possible abnormalities. The midwife today is a teacher in addition to her other functions. She must teach the principles of physiological living in relationship to pregnancy, the details of exercise, clothing, feeding, et cetera . . . Much of it can be done in the home and even more, both for group and individual teaching at a centre . . . In some areas clinics for instruction in the preparation of breast feeding have been established under the charge of midwives. "It seems to us," says the working party report upon midwives (1949), "that the doctor and midwife are complementary . . . the doctor must accept the midwife as his fellow practitioner and not attempt to relegate her to the station of his handmaiden or to displace her unnecessarily from the position of authority in the patient's eyes. The midwife for her part must not be over-possessive about 'her' patients and must be ready and willing to summon the doctor whenever abnormality, pending or overt, requires his skill . . . the public will not be properly served unless all work together as partners in a team." The report goes on to say that the proper duty of a midwife is to practise normal midwifery, to be expert in normal child-bearing in all its varied aspects and over the whole of pregnancy, delivery and puerperum. The doctor's part is to be her partner in detection and treatment of abnormalities, and the health visitor joins with her in attention to social factors and teaching of health and to share particularly in rearing of the child so that there is a considered transfer of responsibility at the end of the midwife's period of supervision.

There we must leave this slow process of evolution of the midwife in Britain; it will almost certainly continue. We believe in her as we do in the family doctor. The future is likely to see the progress of both doctor and midwife in partnership towards a fuller appreciation of the promotion of health and the prevention of disease in the family setting.

The man who does nothing but wait for his ship to come in has already missed the boat. — *Eldon Pederson.*

The Dominion linoleum in this public utility cafeteria helps to deaden the clatter of dishes, the scraping of chairs, the sound of footsteps. So it makes conversation easy and mealtimes restful. Ask your architect or flooring contractor about linoleum when you plan to build or renovate.

Linoleum is "à la mode"

LINOLEUM is a traditional product which has come into new prominence and popularity with the modern mode for colour and design. It has an unmatched combination of qualities both economic and artistic.

On the *economic* side, it is easy on cleaning and maintenance bills, it deadens sound, is resiliently pleasant underfoot, is durable and germicidal.

Artistically, it offers unequalled scope for colour harmonies and attractive designs which direct traffic and emphasize the spirit and function of the place. Today, architects and interior decorators are making increasing use of the decorative and practical possibilities of linoleum.

MARBOLEUM • JASPÉ LINOLEUM • BATTLESHIP (plain)
in tiles or by-the-yard—products of
DOMINION OILCLOTH & LINOLEUM COMPANY LIMITED
Montreal

Time-Tested

FOR ANY WEAR ON ANY FLOOR ANYWHERE

Linoleum has been time-tested and proved by over forty years of wear on the floors of Canadian restaurants, schools, stores, hospitals and public buildings of all kinds. Send for illustrations of what is being done these days with linoleum with its 65 colours and patterns to choose from and combine.

1952
is our 80th Anniversary

Marboleum
BEAUTIFUL
RESILIENT · TIME-TESTED

Medical Staff By-laws

(Concluded from page 74)

tribution of the fee for service. I am sure that, if this could be done, we would all get along much more happily and efficiently.

In the by-laws of some hospitals the surgical service is the only one for which qualification is required. I think that qualification should apply to all services. A severe diabetic or a heart case is often more in need of skilled medical care than some surgical cases.

The chief of each service is responsible for and must supervise the clinical work of his department and see that there are adequate diagnostic and therapeutic facilities available.

The credentials committee is very important and it might be well to state, briefly, some of its duties.

It considers applications for membership and investigates the character, qualifications and standing of each applicant. It recommends to which staff the applicant should be appointed and defines the extent of privileges to be granted within the departments and services.

This committee also receives and considers applications for promotion in any department.

It also acts as a nominating committee for the different elective offices, such as president, vice-president, secretary, and chairmen of standing committees. It convenes before the annual meeting in order to select candidates for these positions.

In the matter of operating room privileges, those who wish to qualify must be staff members who are certified or who hold an equivalent standing. All those who are considered by type, experience, quality and years of practice are eligible—after approval by the credentials committee. It must be remembered that the grading of professional privileges in the hospital shall not be dependent upon certification.

In our hospital, the active staff has its senior and junior divisions. The senior members of the staff must hold standards of certification or the equivalent, while the junior staff is composed of less experienced men. It is the duty of the senior members to teach, train, and guide the junior staff and to encourage them to improve their standing by further post-graduate work and study.

Senior staff members have full operating room privileges while the junior members have partial, or controlled privileges. The junior members must have a senior member assisting them, at all times, and in all major procedures there must be a written consultation with a senior surgeon. The chief of surgery may ask for a consultation at any time or may defer an operation. As chief of staff, he also has the privilege of viewing any operation performed in the hospital. All complaints and violations are investigated and reported by the credentials committee.

General Practitioners

Medical schools and teaching hospitals do not know or realize the needs of the general practitioners in small communities. They have been concerned chiefly with turning out specialists. Now, that these fields are becoming filled, the general practitioner is coming in for more consideration. What course of training a general practitioner should have, and what standards should be required, are questions that I will leave to our universities and general practitioners' sections to work out together. I feel that at least six months or possibly a year should be spent in a so-called small general hospital which is maintaining an approved standard. I would suggest that one month of this internship should be spent in a community or a Red Cross Outpost Hospital.

In conclusion I would stress again that, although establishing satisfactory by-laws in a small hospital is often a difficult and complex process, it is well worth the effort both in improved efficiency and better staff relations.

Niagara Cottage Hospital

(Concluded from page 35)

ates many features of modern design. It has concrete floor slabs, brick and concrete block walls, and complete cork insulation in walls and roof. Floors are covered with linoleum and have terrazzo base and dados. Throughout the building, ample storage space has been reserved for supplies of every description.

The exceptionally clean and compact boiler room provides a stoker-fired hot water boiler for economical, low-temperature heating. Combination radiant-convection radiators ensure the hospital of comfortable, even heat.

It is refreshing to know in these days of high costs that this well-designed, well-equipped hospital was built and furnished for the low price of $7,000 per bed. Much of the equipment and furnishings were purchased with money contributed by residents of the area.

Capturing the quiet charm of the community, the Niagara Cottage Hospital does not sacrifice beauty in the interest of hospital efficiency and is an excellent example of what a small community is capable of providing in hospital construction.

Maritime Hospital Association

(Concluded from page 46)

to all distinguished government and civic officials for their presence and help at the meeting and to the various speakers and discussion leaders.

The Association also expressed its appreciation to the Sun Life Assurance Co., for its continued support to the Canadian Hospital Council. It promised to continue to support and co-operate with Blue Cross organizations and continued to urge on its member hospitals the pressing need of good public relations. The Association wished to give consideration to promoting a national broadcast of the talk on this subject given at the meeting by Mr. Donald Henshaw, Toronto.

The Association went on record as re-iterating its stand on the matter of unemployment insurance as expressed in resolutions passed at the 1951 convention. It requested the Canadian Hospital Council to urge, in relation to any proposal which may be advanced for a system of health insurance, that the advantages of fully utilizing available and established pre-payment hospitalization plans be not overlooked.

A resolution was passed to the effect that a committee be formed to study the possibility of establishing an experimental Central School of Nursing as a potential nucleous for a future master plan of Regional Schools of Nursing throughout the Maritimes, based educationally on the principles of the independent school of nursing at present being worked out at Toronto Western Hospital.

The Association urged the governments of Nova Scotia, New Brunswick, and Newfoundland to implement legislation recognizing, defining, and setting standards for the nursing assistant profession.

It was also resolved that the Association extend to the executive grateful appreciation for their energetic and productive efforts.—*M.W.R.*

Hospital at Tofino, B.C., Destroyed by Fire

Early in May fire destroyed the two-storey Tofino General Hospital, Tofino, B.C. At the time of the fire seven patients were in hospital but quick thinking and speedy action on the part of the staff and local citizens ensured their safe removal to the nearby community hall. The blaze, which began on the second floor, progressed downward rapidly but firemen and volunteers were able to save most of the equipment, including surgical and x-ray apparatus, as well as the hospital records. Flames encompassed the entire building in a few minutes so firemen concentrated on saving the nurses' residence which is now being used as a temporary hospital. The loss of the institution's services will affect some 2,500 residents in the town and surrounding district as it provided the only hospital facilities between Port Alberni and Esperanza.

. . . Across the Desk

Perfect Matching Colours of Kalistron

A photo-electric eye that eliminates colour guesswork is now being used by Paul Collet & Co. Limited, manufacturers and distributors of Kalistron.

In the past, matching colour was done by the human eye and varied to some degree as light changed and eyes became weary. The photo-electric eye measures the sensitivity of colour to the eye and then registers the colour by number. Use of this machine, believed to be the first in this field in Canada, allows colours to be perfectly matched months and years after their original production.

The electronic eye will be used in the production of Kalistron, a "Vinylite" sheeting especially designed for areas or articles where hard usage is encountered, with colour fused to the underside to protect it against scratching, scuffing and other types of wearing action.

* * *

Edwards of Canada Now Located at Owen Sound

Edwards of Canada Limited have moved their head office and factory from Montreal to Owen Sound, Ontario. A new and much larger factory than their Montreal quarters has just been completed.

In their new plant they will manufacture their well known range of nurses' call, doctors' paging, doctors' in & out equipment, as well as fire alarm systems, telephone systems and clock systems; and their renowned line of bells, buzzers, push buttons, and annunciators.

Sales offices will be maintained in Saint John, N.B., Montreal, Toronto, Winnipeg, Calgary, Edmonton and Vancouver.

Exhibitors at Maritime Hospital Meeting

More than 40 exhibits of hospital supplies and equipment added much colour and interest to the 10th annual convention of the Maritime Hospital

Alex. P. McGovern

Association at the Algonquin Hotel, St. Andrews, N.B., June 6-9.

At their annual meeting the Maritime Hospital Exhibitors Association elected Alex P. McGovern of the Ferranti Electric Co., Halifax, to succeed E. J. Holland of Halifax, as president of the Association.

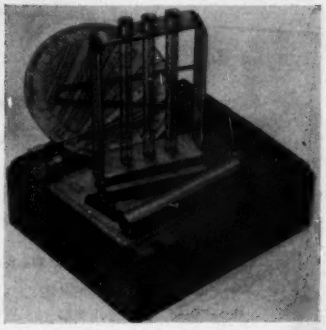
Other officers elected were J. P. Murphy, Halifax, Vice-president; C. M. Carpenter, Moncton, Secretary-Treasurer; and regional representatives Robert Watt, Sackville; B. Babcock, Halifax; J. R. Sowerby, Montreal; and Earle Wicklum, Toronto.

* * *

New Clay-Adams Product

A complete, simplified physician's kit, enabling the doctor to perform Wintrobe blood sedimentation tests easily in his own office, has been announced by Clay-Adams Co. Inc.

The new kit contains two important features that simplify the testing procedure. First is the new convenient Best calculator, designed by Dr. William R. Best. Corrected sedimentation rates may be read directly from this circular calculator, eliminating the need for referring to complicated curve charts.



Also included in the kit is a new syringe cannula that is used for taking the blood sample from the patient and for filling the Wintrobe tube, eliminating an extra step in the procedure.

Form 525, containing complete details on the Wintrobe blood sedimentation kit, is available from Clay-Adams, Co., Inc., 141 East 25th Street, New York 10, N.Y.

* * *

New Electric Roast and General Purpose Ovens

A complete line of functionally designed electric ovens for roasting or general oven cooking in hospitals, restaurants, hotels, and institutions is now available. These have been designed and produced in Canada to meet Canadian conditions.

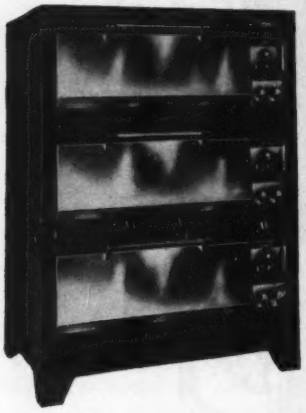
Clean cut modern styling is incorporated with important features of construction such as full width stainless doors of shelf type having extra heavy insulation, particularly on the 39" size. Smaller 24" wide ovens are available in two depths, 28" and 33". All ovens have front access to fuses and springs, so that proper placement in the kitchen can always be made. All ovens except the smallest size are

(Concluded on page 96)

Across the Desk

(Concluded from page 94)

available in one, two or three decks, each operating on an independent unit for greater flexibility of cooking.



Full specifications are available from dealers or direct from the manufacturer, the Empire Stove & Furnace Company Ltd., Owen Sound, Ont.

* * *

Charles G. Nelson Manager of Angelica Uniform Co.

Angelica Uniform Co. of Canada Limited has announced the appointment of Mr. Charles G. Nelson as Manager of its entire Canadian operation.

Mr. Nelson, who will have his offices at 427 St. Francois Xavier Street, Montreal, is a native of Canada, and his executive capacities include over 21 years' experience in sales, merchandising, and production in the uniform field.

Charles G. Nelson

In making the appointment, Angelica's President said: "Mr. Nelson has a wide and varied expeprience and thoroughly understands the needs of the Canadian trade. He will be able to make better service a reality and will be in charge of the large sales force of direct factory salesmen who handle Angelica washable uniforms and hospital apparel exclusively.

A family man, Mr. Nelson has a wife and two small sons. He is a member of the Montreal Amateur Athletic Association and is also active in civic affairs.

* * *

Monitor Controls Radiation

Patients receiving x-ray treatment at a hospital in Cleveland are assured, by means of a small device called a radiation monitor, that the treatment is confined to diseased areas. At the same time, hospital personnel can also be confident that they are not being

exposed to excessive radiation while administering treatment.

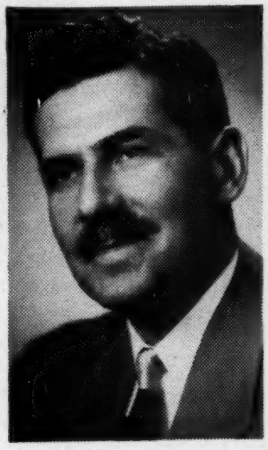
Developed by the General Electric Company, the monitor is about the size of a quart fruit jar and indicates the radiation present in an area at a given time. When patients undergo ex-ray treatments, the device is placed beside them so that they can check the amount of stray radiation they receive. Doctors say that the presence of the monitor relaxes patients and provides them with confidence while they are undergoing treatment.

Further information available from any office of General Electric X-ray Corporation Limited.

New Appointment For Leonard A. McGlashan

A. Eyre Davis, Vice-President and Sales Manager of McGlashan, Clarke Co. Limited, Niagara Falls and Toronto, announces the appointment of Leonard McGlashan as sales representative for Ontario.

Mr. McGlashan is married and has four children. He was educated in Niagara Falls and St. Catharines;



Leonard A. McGlashan

during the war served with the R.C.A.F. He has had a number of years of technical experience in silverplating.

* * * *

Hellige "Three-Line" Blood Diluting Pipettes

The Hellige-originated "Three-Line" Pipettes for red and white corpuscles differ from the customary style in that they are engraved with only an 0.5 mark in addition to the 1 and 101 marks required for red pipettes and the 1 and 11 marks required for white pipettes.

There are only 3 graduations instead of 11. The other 8 markings that are customarily placed on the stem of regular Thoma pipettes are of no practical value and only serve to confuse, according to the manufacturers. The widely spaced graduations on Hellige "Three-Line" pipettes and the freedom from superfluous markings eliminate a source of errors. Pipettes are packed individually in boxes, one dozen to a carton. Exclusively manufactured by Hellige Inc., 3718 Northern Boulevard, Long Island City, N.Y.

The Western Institute

(Concluded from page 72)

expressed by all present. Mr. Shannon was requested to contact the secretaries of the associations in British Columbia, Alberta, and Saskatchewan and attempt to obtain a degree of uniformity in respect to rates charged for exhibit space.

Those present were unanimous in offering their congratulations to Percy Ward and the program committee for the excellent program which had been arranged for the 1952 institute in Vancouver.

Hospital Tours

The bus tours arranged for Wednesday afternoon constituted an interesting feature of the institute. Students were able to spend two hours in any one of ten hospitals in the lower mainland area of British Columbia or to make a complete round trip to view the exteriors of all hospitals and the beautiful countryside.

That evening students, visitors, and staff gathered at the Brock Lounge on the campus for the institute dinner and dance. Presentation of the Judge and Mrs. J. M. George award for the best essay on "How May Auxiliaries Best Assist their Hospitals?" was made during the dinner. Judge George of Morden, Man., officiated at the ceremony and awarded the prize to the winner, Mrs. J. S. G. McMurtry of the women's auxiliary to the Vernon Jubilee Hospital, Vernon, B.C.

In Appreciation

All those who attended this, the 7th Western Canada Institute for Hospital Administrators and Trustees will wish to express to the local committee, and especially to Mr. Percy Ward, their appreciation of an excellent program and their gratitude for all the work involved in preliminary arrangements.—*Jessie Fraser.*

Impatience

After several hours of luckless fishing, the little girl suddenly threw down her pole and cried, "I quit."

"What's the matter?" her father asked.

"Nothing," said the child, "except that I can't seem to get waited on."

Index of Advertisers

JULY, 1952

Authorized as Second Class Mail, Post Office Department, Ottawa. The Canadian Hospital is published monthly by The Canadian Hospital Council, 57 Bloor Street West, Toronto 5.

MADE-TO-ORDER

Hospital Apparel & Cotton Appliances

• • • •

Place your requirements now with CORBETT-COWLEY

Section Sheets	Perineal Drapes
Stand Covers	Laparotomy Sheets
Air Ring Covers	Lithotomy Sheets
Stupe Wringers	Spinal Sheets
Shoe Covers	Thyroid Sheets
Glove Envelopes	Arm Bands
Masks	Hot Water Bottle Covers
Ice Bag Covers	Cataract Frames
Binders	Examination Capes
Leg Holders, etc.	Pneumonia Jackets.

These items may be had from stock, or made up precisely to your own specifications. Quotations supplied promptly on request.

OPERATING GOWNS—in color, white or unbleached
PATIENTS' BEDGOWNS—bleached or unbleached
INTERNE SUITS—male and ladies'
Laboratory & Technicians' COATS—white, tan, gray

ORDER SOON FOR EARLY DELIVERY

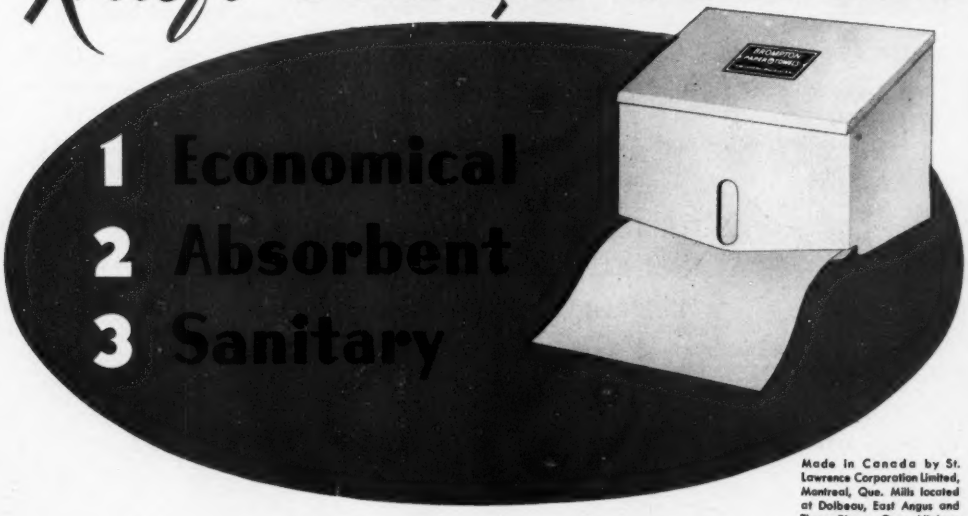
CORBETT-COWLEY
Limited

2738 Dundas Street West, Toronto 9, Ont. — 424 St. Helene Street, Montreal 1, Que.

3 GOOD REASONS FOR USING

BROMPTON K-20

Kraft PAPER TOWELS



Made in Canada by St. Lawrence Corporation Limited, Montreal, Que. Mills located at Dolbeau, East Angus and Three Rivers, Que., Nipigon and Red Rock, Ont.

G. H. WOOD & COMPANY LIMITED

SANITATION FOR THE NATION • BRANCHES THROUGHOUT CANADA